Contextualising the coordination of care in NHS trusts: an organisational perspective

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An Organisational Perspective

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For Louise and Joshua

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The thesis draws upon and extends work undertaken as part of the Clinical Work Management Development (CMD) project in the Wolfson Research Institute, University of Durham, for which I was the project manager and co-researcher. The CMD project ran in Northern England and Yorkshire from Feb 2002-Mar 2005; the project report (Maxwell, Degeling, Kennedy, and Coyle 2005) was written in 2005. Chapter Eight of this thesis reports survey results from close ended questions about issues facing the healthcare system, beliefs about the nature of clinical work, and views on clinical and organisational management; it reproduces one chapter of the CDM project almost in its entirety. Chapter Nine reports survey results about staff's experience work and their views on work improvement. Though these data were also gathered during the Clinical Management Development project, the results have not previously been fully analysed nor have they been published elsewhere. Parts of Chapter Three, Method, necessarily also draw upon relevant sections of the method chapter in the CMD project report.

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Abbreviations

CCMD	Centre for Clinical Management Development
CDMP	Clinical Management Development Project
CEO	Chief Executive Officer
CG	Clinical Governance
CGSU	Clinical Governance Support Unit
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CMD	Clinical Management Development project
CMF	Clinical Modernisation Forum
CMS	Clinical Management Structure
CPB	Clinical Policy Board
CRH	Calderdale Royal Hospital
CWD	Clinical Work Development Board
DoH	Department of Health
DoN	Director of Nursing
Fin Dir	Financial Director
HRI	Huddersfield Royal Infirmary
ICP	Integrated Clinical Pathway
IMT	Information Management and Technology
MBI	Management Budgeting Initiative
Med Dir	Medical Director
NICE	National Institute of Clinical Excellence
NHS	National Health Service
NSF	National service Framework
NTH	North Tees and Hartlepool NHS Trust
OD	Organisational Development
OD Dir	Organisational Director
PSC	Pathways Steering Committee
PCT	Primary Care Trust
TDG	Trust Directors' Group
RMI	Resource Management Initiative
UHH	University Hospital of Hartlepool
UHTH	University Hospital of North Tees

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This thesis has two principal aims. The first is to understand why change oriented towards improving the coordination of care for long term users of healthcare (and related) services is so difficult to achieve. The second is to identify possibilities for how these difficulties may be overcome.

During the three-year period 2002-2004, two NHS Trusts instituted a particular means for coordinating care, integrated care pathways (ICPs), as 'the way that clinical work is done here'. These change efforts were instigated as part of a collaborative NHS modernisation project. Despite similarities between the Trusts and their change programmes, the organisational outcomes from the modernisation project differed. This thesis identifies factors that contributed to these differing outcomes.

The research was framed within an organisational perspective drawing upon recent organisational theory and a relevant research approach; interpretative structuralism. This approach used a variety of research techniques (historical analysis, document review, surveys and interviewing) to examine the social contexts underpinning prevailing thinking within the NHS about how clinical work should be organised and managed.

The results showed that many factors in the wider context of the NHS and the local clinical 'shop floor' operate to fragment thinking about how care should be organised. In one Trust several factors contributed to its greater success in implementing ICPs. These included (i) coherence and congruence amongst the senior management in conceptualising and pursuing more product oriented approaches to clinical management, (ii) clinically led services and devolution of authority, (iii) a willingness of all staff (including senior management and clinicians) to be self critical and thoughtful in making suggestions for improving clinical performance, and (iv) an ability by senior management to interweave five key themes in clinical service provision throughout the organisation. These themes were patient experience, service redesign, financial balance, the inter-relationship between these three, and integrated governance of the resulting organisational processes and outcomes.

The results also showed that local contextual factors such as the character of the local electorate and the style and expected longevity of the senior leadership can undermine success in achieving agreed goals for coordinating and managing care.

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Chapter One

Rationale

The Research Question

This research aims to provide insight into the questions: What prevents service providers from structuring their services in a more 'organised yet flexible' way? More specifically, what prevents integrative innovations in care organisation and management such as integrated care pathways from being implemented effectively? And, consequent upon that, how might these impediments be overcome?

Why Integrated Care Pathway (ICP) Implementation?

My research interest and commitment to exploring these questions grew out of personal experience of the apparent disorganisation of care over many years as a care giver and patient advocate. ICPs offer a way to organise care in a more efficient, effective and transparent manner, yet experience has shown that they are not as widely used as they might be and their successful implementation is not guaranteed.

My Story

I am the mother of a nineteen year old son with Down's Syndrome who also has severe-profound speech dyspraxia and, until puberty, a hearing problem and a sleep disorder. When my son was born I joined my local Down Syndrome Association (DSA) (in New South Wales, Australia) in order to obtain support for my family in understanding and managing what my son's disability would mean for family life and for the future. The DSA proved invaluable in helping me to negotiate the complexities of health, educational and social care provision.

Even so, the 'postcode lottery' in availability of services, the differing criteria for accessing services, the lack of communication and shared knowledge between health professionals and between health and educational specialists, and the constant requirements for me to meet yet more specialists and therapists, meant I struggled to access services in a coherent and helpful way. When I did succeed in accessing services, I spent much of my time repeating history and needs I had already told every other professional my son and family had encountered along the way. The frustrations from feeling 'all at sea' without direction regarding the availability of services, the logistical difficulties involved in accessing services once they had been 'discovered',

the seeming futility of the extensive 'filling in' of forms, and the weariness and exasperation in repeated retelling of the same old story over and over again became particularly acute when I had my second child. As a baby, there was the difficulty of being unable to develop sleep and other routines with her, due to the need to constantly interrupt these to take my son somewhere for his treatment and assessment. As a toddler, there was the difficulty of trying to attend simultaneously to the exploratory and/or attention seeking behaviour of a two-three year old whilst having a detailed discussion with a health professional about my son's needs. As a school aged child, who was both athletic and subsequently assessed as 'intellectually advanced', there was the ongoing and seemingly unwinnable battle to grow and keep a close family with two children who, physically and intellectually, lived at opposite ends of the spectrum. Why, I fumed, could health professionals not coordinate services better, communicate more effectively amongst themselves and between services, and plan how streams of care could be delivered to people and families with well known and relatively consistent sets of needs? It was not as if people with learning disabilities in general and Down's Syndrome in particular were unknown entities, whose needs were unknown and whose requirements could not be anticipated and planned in advance. Surely better organisation would reduce the stress upon families from the existing disorganisation between services?

My work as a volunteer family support worker and patient advocate on the DSA's behalf and as a clergy wife led me to extensive involvement with other families with similar problems. I realised that many of these families struggled with a combination of disability, mental health and other problems. It seemed that the stress of dealing with combined intellectual and physical disability often resulted in parents of these children developing some form of mental illness especially, though not solely, depression, anxiety and/or phobias. The mental health problems I encountered through my role as clergy wife were usually more severe than those I encountered in my work with the DSA; nonetheless there was a considerable commonality in the experiences and needs of families. Often the burdens of the first person's mental illness would trigger (or be associated with) mental illness in another family member. It was not unusual, for

example, to encounter a family with a son who was schizophrenic, a mother who was depressed or highly anxious and a father at his wits' end.

Thus there were many similarities in my experiences in my twin roles and in my own personal existence. The problem was, and is, widespread though perhaps not widely recognised. Families with complex circumstances commonly endure fragmented, 'silo'-type service provision. The problem is not that the individual services offered to each family member were/are poor, indeed despite waiting lists, services are often excellent once accessed. It was/is that the services are offered in isolation from, and even in ignorance of, other relevant services and from the families' wider needs.

One situation I commonly encountered is the 'be present or be relegated' scenario. In this scenario, care service 'x' would arrange an appointment for a relevant family member at a particular locality at a particular time. There would be one 'grace' re-arrangement of the appointment i.e. if there was a reason why that appointment could not be made, another appointment would be made. If that next appointment was not kept, for whatever reason, the patient/client would go to the end of the queue. In one example that caused particular vexation for me, a mother with agoraphobia was asked to take her disabled son to a facility nine kilometres distant for speech therapy. The child had been on the waiting list for nearly a year. The mother had two pre-school age children in addition to the disabled son. Though geographically not far, the facility was not easily accessible by public transport; it would require several changes of buses to get there. It was never going to be easy to get the child there – most days the mother could not even get out of her house, let alone make a trip of this complexity with this many children. When the speech therapy centre was contacted to ask if the therapist could come to the child instead, the response was a firm 'no'. The rationale for the parents coming to the centre, it was explained, was that this allowed the therapists (who were short-staffed) to maximise the number of clients they could see in a day. This practice prevented the loss of significant therapy time through unnecessary travelling (from the perspective of the service provider). This was an understandable and, from a service efficiency perspective, sound response but it did not take account of the family's situation.

The mother did not manage to make the first appointment. For the next appointment, we were highly organised. Transport was arranged to the centre, the mother was coached and encouraged in how to deal with the (to her) traumatic experience of going so far outside her home. Child minders were arranged for the younger children. The father had arranged to call his wife from work and talk her through the journey if she found the travel tough going. However two days before the appointment, the son broke out with chicken pox and was not able to attend. Despite our intensive efforts and repeated requests for consideration for another appointment in a few weeks, the family lost their place in the queue and had to start the waiting list process over again. The mother in particular was greatly demoralised at the outcome. Though this experience occurred in Australia, it is similar to the anecdotal experiences of families I met when I moved to the UK.

Another frequently encountered situation was the failure to get rapid access to mental health care when required. Despite obvious indications that all was not well with someone with diagnosed mental illness, it was often exceedingly difficult to get a health professional to intervene. This was true even when the person had been hospitalised more than once previously. Regardless of how much pressure the family member with the mental health problem placed upon their family (usually through refusing to take their medication), people with poor mental health were deemed to be better off in the community. In addition, the patient's right to privacy was deemed paramount over the needs of the family to prevent or manage the dysfunction and chaos caused by the family member's refusal to self-medicate. In the longer term, the result was usually even more dysfunction and mental illness in the family and increased need for social welfare.

Feeling under-equipped to help individuals and families deal with the emotions, discouragements and despair that such intractable circumstances generate in vulnerable people, I trained as a personal counsellor. My aim was to be more skilful and insightful in helping the families I supported. Before I had completed the 200 hours of counselling experience necessary for registration, I came to several realisations. The first of these was that I was not necessarily well equipped to take more responsibility

for (and exposure to) the emotional pain of others. The second was that the 'system' was letting people down faster than I could help put them back together. It seemed clear to me that, amongst the particular patient/family groups with whom I was working, the health system in particular and, to a lesser extent the related social and education systems, were frequently though unintentionally creating more, rather than fewer, health problems. Those affected were often amongst the some of most vulnerable people in society. On ethical, societal and (from a health system perspective) instrumental grounds this was, to me, unacceptable, especially in a western country. From an economic perspective (my first degree was in economics), it was inefficient and short-sighted; strong economies require a competitive edge and a productive workforce. The growing rates of depression and other mental illness in western economies were already being recognised as potentially undermining workforce productivity and the ability of western countries to provide for their members, including the relatively well. This was no less true of Australia. The increased incapacity of families with complex needs simply added to the economic problem. Though my interest in better coordinated, patient and family centred services was initially 'selfish', the ramifications were potentially serious to all. Much later, I came to realise that many of these problems are also experienced, though to a lesser extent, by families with members who have long term (chronic) conditions.

I decided I was misdirecting my efforts. If I wanted to make a difference, I would be better off working towards a changed system which prevented these kinds of situations, rather than trying to hold a few people together once they'd 'gone through the mill' and been crushed.

Initial Efforts to Understand the Issue of Service Inflexibility

In my ignorance at this stage, I believed that my relatively ineffectual efforts as a family/patient advocate were the result of my voluntary status (which was definitely a hindrance on many occasions) and my lack of direct knowledge about the health service. I reasoned that to be an effective change agent, I needed to get some healthcare qualifications, to become an 'insider', and work to change the system from that knowledge base. My intention upon gaining a relevant degree was to work in a

community health organisation which focused upon care provision to either people with a learning disability or a mental health problem. I therefore applied, on the basis of my volunteer work, for admission to a Masters degree in health service management.

The first indication that this would not necessarily provide the understanding that I sought came in the very first lecture which was on health systems. The lecturer asked all 60 or so people in the lecture theatre to provide their names, health related role and reason for undertaking the course. As I gave my reasons and role, a doctor at the back of the lecture theatre angrily announced that he had been in the health service for nine years and *he'd* never been able to access the services *he* required for *his* patients. *He* never had any impact on the system, so what right did *I* have to think that *I* could do better than *he* had? He went on to say that he felt just as much an outsider to the organisation of care as I did. The lecture was silent with held breath until other doctors also began to vent their frustration with 'the system'. It was a rude awakening for me to the frustrations inherent in the existing organisation and management of care, but a necessary one.

The Masters programme was intellectually useful however the programme was taught principally from an instrumentalist perspective. Lectures, readings and exercises conveyed the impression that all one had to do was align the goals, strategies and incentives, press the 'go' button, and the desired solution would result. This did not explain why so many health professionals felt locked out of the system in which they were employed. Greater insight came from understanding the lived experience of the organisation and management of care by doctors, nurses, therapists, health scientists and managers. My discussions with practising health professionals suggested that instrumentalism in health service organisation, particularly at the level at which clinical work was done, was more illusion than reality. I gleaned strong impressions that the (Australian) health service was often long term, thinly disguised chaos, held together by goodwill and dedication from all who worked there, often despite very strong differences of opinion between professionals about what was in fact the best or right way to do something.

Learning about ICPS

As a result of my progress on the Masters, I was invited to work with Professor Pieter Degeling, then of the Centre for Hospital Management and Information Systems Research in the Faculty of Medicine at the University of New South Wales. My position was editor of the research project report on professional sub-cultures in hospitals that Professor Degeling was writing. This report confirmed, via quantitative research findings, impressions I had developed from personal experience and the anecdotes of my new study colleagues. The Australian health service (in this case hospitals) was marked by deeply entrenched professional disagreements and sub-cultural stances on almost every aspect of healthcare provision including how care should be organised, how standards should be set, and how healthcare should be managed.

At that time Professor Degeling became interested in integrated clinical pathways (ICPs) as a mechanism for achieving 'interpolar balance' between the various competing interests and values amongst healthcare professionals. ICPs are systematically developed written statements of the prospective trajectory of care for patients with a specific clinical condition e.g. a fractured neck of femur, stroke or with an ongoing chronic disease. They incorporate the views of clinicians (medical, nursing, allied health), patients, managers and carers about the agreed sequence of the phases and events in primary, acute and/or community care that will significantly affect quality and outcomes. The terminology of ICPs is not yet settled – they are variously described in the literature as critical paths, care maps, multidisciplinary action plans, care paths, research protocols, guidelines, algorithms, collaborative care pathways, problem orientated medical records, and anticipated recovery pathways. One of the most widely used definitions comprises three central components: a collectively agreed, prospectively planned package of care; a nominated person responsible for case management; and variance analysis and audit (Ignatavicius and Hausman 1995). However, if ICPs are understood as a health sector application of (industrial) process management, then an ICP will also include a fourth component, namely prospective costing of the outlined care. I was intrigued as ICPs seemed to be a means for providing that structured yet flexible organisation of care I was seeking for people with relatively complex and ongoing health needs.

Professor Degeling sought and achieved a major research grant to examine the practical outcomes of ICPs as an organising tool. A three year, three clinical condition research project was undertaken in three Australian states. This project, for which I was a researcher, suggested that ICPs offered a way to ensure higher quality coordinated care, efficiently and effectively (Degeling, Sorensen, Maxwell, Aisbett, Zhang, and Coyle 2000b). This confirmed what the academic literature, especially the nursing based literature, had been claiming for ICPs for about ten years. Contrary to the largely exhortatory published literature on ICPs at that time however, it also uncovered some of the reasons why ICPS might not necessarily be as well accepted and implemented as they could be. The reasons for this included:

- Managements' priority to manage 'up' in response to political pressure and imposed targets,
- The dynamics of management/clinician relationships, including relative power relations, and
- Limited 'vision' i.e. it is very hard to imagine something that has not yet been seen, even when similar concepts exist in other economic sectors.

Other researchers working with Prof Degeling in other projects at that time discovered that language, semiotics and power relationships also played significant roles in determining whether and how ICPs were adopted and what their outcomes might be.

Yet something else was evidently also at work. In 2002, along with Professor Degeling and two others, I began work as the project manager on what became known as the Clinical Management Development project (CMDP). This project was an initiative of the then Northern and Yorkshire Regional Modernisation Board. It was a three year research and development project with a remit to operate in six local health economies in the North of England and Yorkshire. In truth, however, each health economy's involvement was driven by the involvement (or relative lack thereof) of the local NHS Trust. The project's aims were to identify sub-cultural stances on aspects of NHS modernisation, and in the light of identified awareness of these differences, to assist the participating health economies to implement ICPs. Only four health economies eventually participated in the CMDP; of these only two continued to participate into the

development phase. The two health economies which did not start the project withdrew after the local NHS Trusts decided that they had higher priorities; in one Trust this was a recent amalgamation and in the other it was a belief that finance, not the organisation of care, was the key problem faced by the Trust. Of the two health economies which commenced the project but did not complete it, one Trust did not accept that ICPs were a productive way forward and the other believed it could develop ICPs faster by going it alone.

The two remaining health economies agreed that they would implement similar ICPs and similar ICP management structures and processes for three common clinical conditions. These two health economies appeared very similar in composition. The hospital Trusts were both formed out of the amalgamation of previous trusts relatively recently prior to the commencement of the CMD project. They both had two principal district general hospitals located in geographically distinct and competitive townships. They both had politically active local constituencies, significant inherited debt, and operated with a divisionalised internal structure. Both had three Primary Care Trusts (PCTs) that, reflecting the geographical and political sensitivities, did not always see eye to eye. Yet the CMDP had very different outcomes in the two health economies and particularly in the NHS Trusts. By the end of the project, ICPs in one Trust appeared to be becoming 'part of the way we do things here'; in the other, despite some gains on paper, there were few concrete results. The question for me was, and is, "Why was this so?" "Why did ICPs become more institutionalised in one Trust than the other?"

Superficially and intuitively, part of the explanation for the different result resided at the level of the CMD project and its management, other explanations were internal to the Trusts, still others were probably the result of interactions between the PCTs, NHS Trusts, Durham University project team and local concerns. Yet almost undeniably, it was apparent that something more fundamental was also at work. The history of the NHS is anecdotally one in which, despite persistent change efforts, the coordination of clinical work remains problematic. The organisation of clinical work is still highly fragmented, plagued by problems in communication and coordination, and heavily

orientated towards the needs of the service provider rather than the service user (and their family).

My Focus and My Method

During this work on ICPs I established my employment within the higher education sector. On a professional level, I needed to undertake a PhD to further my career as an academic. On a personal leave I was still vexed by the difficulties in achieving more coordinated care. A PhD offered the possibility to achieve both goals. Recognising that that studying the coordination of care within and across the related sectors of health, social care and education was an enormous undertaking, I knew I needed to narrow my PhD focus and more tightly define my research question. Highly regarded cross-sectoral work about joint working and planning was already being undertaken by Professor Bob Hudson. It made sense from strategic and logistic considerations (i.e. what could make a real contribution to knowledge and be manageable within the required time frame given my personal circumstances and time availability?) to focus upon the coordination of care in one sector. It also made sense to focus specifically upon one example of various putative means for coordinating and delivering care.

The literature suggests that ICPs have the potential to simultaneously operate within and across organisations within one sector and across sectors yet my work experience had shown that even with significant funding, expert input and a reasonable time horizon, change in the organisation of clinical work within individual organisations had proven relatively difficult to effect. I therefore decided to focus my PhD around the identification of factors that may have contributed to the differing outcomes in the two NHS Trusts central to the CMDP. I regarded these as exemplars for understanding what impedes and/or facilitates the adoption and implementation of specific innovations in clinical work organisation and management, particularly ones directed at integrating and coordinating the care for nominated patient groups. I hoped these findings would be generalisable; firstly within hospitals and, perhaps even more broadly, across healthcare and other organisations and secondly, to other forms of innovation in clinical work methods.

Several possible causes for the differing results were available in organisational theory and business management literatures, especially papers which focused on healthcare. The health professional literatures also suggested possibilities. The potential causes included entrenched professional cultures, poor leadership and lack of vision, poor change management practices, the effectiveness (or not) of clinical teams, the deeper 'structures' of management and clinician relations, lack of political awareness amongst managers, and poor organisation communication and learning. Each of these explanations appeared to be relevant but they were also interrelated. Moreover I was not sure how insightful any one of these explanations might turn out to be, or how generalisable any results might be.

I decided that, rather than favour one theory or explanation over another, I would examine the contextual environment of ICP implementation in the wider NHS and in these particular Trusts. My goal was to understand how a variety of contextual factors interact within healthcare organisations to affect how clinical work is managed and thus how new modes of organising clinical work may be introduced. As I could not examine all contextual factors I chose to examine the following factors:

- Historical factors,
- Professional sub-cultures,
- Staff views on their experience of work and its possible improvement, and
- Conceptions and strategies re the organisation and management of clinical work amongst senior management.

My reasons for choosing these factors were intertwined with my choice of method. Since I was looking for explanations for the persistence of established practices and modes of clinical work organisation (or the lack thereof) within organisations, I looked to research by organisational theorists as my starting point and then to methods being used within such research. I chose as my method 'interpretative structuralism'. According to Hardy and Phillips (Phillips and Hardy 2002), interpretative structuralism is a methodological approach which emphasises the importance of the social context underpinning the prevailing way of thinking about and making sense of something and

how that has been, and continues to be, constructed. It allowed me to analyse and interpret the contribution the social contexts of clinical work organisation and management (within the study organisations and within the wider organisational environment) make in structuring (or institutionalising) thinking about planning, organising and managing clinical work.

The Structure of this Thesis

The thesis begins with the outline of the rationale for examining the social context for the organisation of clinical work provided in this Chapter. Chapter Two contextualises and overviews literature on a selection of themes relevant to how clinical work is conducted and organised within organisations, primarily hospitals. The research method is outlined in Chapter Three. Chapter Four reviews the NHS and managerial decision making structures within hospitals from a historical perspective whilst Chapter Five reviews health policies, prior to and during the Clinical Management Development project, which sought to change the way clinical work is viewed, conducted, coordinated and monitored within organisations. Chapters Six and Seven are descriptive chapters. Chapter Six provides summaries of the two Trusts, their history, structures and local contexts. Chapter Seven extends this, outlining the Clinical Management Development project and each Trust's participation in this. Findings from the empirical work are reported in Chapters Eight, Nine and Ten. Chapters Eight and Nine report findings from surveys administered to managers and clinicians about factors affecting the healthcare system, the management of healthcare organisations and clinical practice, staff's experience of work and their suggestions for how their experience of work and the Trusts' clinical performance could be improved. Chapter Ten provides a thematic summary of interviews with both Trusts' Executive Team regarding organisational values, priorities and conceptions about clinical work. Chapter Eleven discusses findings, draws conclusions from the research, and discusses its limitations and future possibilities.

Chapter Two

Contextualising Literature Relevant to the Organisation, Coordination and Conduct of Clinical Work

Introduction

Change in the NHS (and the lack thereof) has been a topic of discussion amongst academics, policy analysts and practitioners since the NHS' establishment. For many, the NHS demonstrates that old adage "the more things change, the more they stay the same". This is especially true in regards to the coordination and organisation of clinical work. Despite repeated and major structural reorganisations, programmes that have sought to produce improved coordination of work through increased teamwork, altered skills-mix and/or work practice change have not necessarily produced real change. Explanations for this persistent disparity between goals and achievement of better coordination and delivery of clinical work have been largely sourced in the instrumental aspects of healthcare arrangements. These instrumental explanations for the lack of change can be clustered into various related organisational and regulatory matters although other explanations include political and cultural elements.

Lack of real progress can be attributed to strategic failures such as lack of strategic planning (Sibbald, Shen, and McBride 2004) and discontinuities in leadership of strategic change (Pettigrew, Ferlie, and McKee 1992). Organisational design issues include an absence of organisational supports for changes that take account of the organisational context and structures to support team processes (Borrill et al 2000); management issues that centre around human resource management, especially for middle management (McConville and Holden 1999; T and Holden 1999); and inadequate training of front line staff. This poor training stems from an over-reliance on 'on the job' learning (and resulting absence of formal supervised training) and misjudgement of the gap between staffs' existing and required skills (Briggs 1997; Sibbald, Shen, and McBride 2004). Not surprisingly, this results in difficulties in discontinuing older ways of working and in coordinating the expansion of new roles and work modes (Lowy, Brazier, Fall, Thomas, Jones, and Williams 1993), variable results (Lewis, Tudor, Tsao, and Canaan 1998) and poor quality assurance techniques (Audit Commission 1992).

Regulatory matters add to organisational problems by creating obstacles between care organisations and sectors (e.g. health and social care) seeking to act in partnership.

The most commonly reported regulatory impediments in health are boundary issues, e.g. differing lines of accountability and employment conditions/status within health care sectors (Audit Commission 1992; Sibbald, Shen, and McBride 2004), difficulties in aligning staff remuneration (Audit Commission 1992) (Bailey, Black, and Wilkin 1994; Baker and Klein 1991), and difficulties in role realignments through the lack of firm evidence about cost effectiveness of many substitutions (and therefore lack of management support for them) (Sibbald, Shen, and McBride 2004). A plethora of more abstract instrumental factors facilitating and hindering inter-organisational coordination has been identified in the wider social science literature (including industrial relations, management studies, organisation theory, politics, and social policy)(Hudson 1987; Webb 1991). Important amongst these are the presence or absence of domain consensus, reciprocal trust, incentives, intermediary bodies, power brokers and fixers, and political commitment (Degeling 1995).

Perhaps more importantly, and frequently unacknowledged, this extensive literature is limited by authors' frequent failure to recognise that the very act of naming a formal boundary has both cognitive and social effects. 'Labelling' influences how people think, act and interact within each boundary – it assists the derivation of sense and meaning by implicitly delineating what is 'inside' and what is 'outside' the boundary. In so doing, people, especially but not exclusively the insiders, shape various complex ideas, processes and associated activities into a coherent, reified whole. This 'reification' presents social processes and cultural expressions as concrete, factual objects and imbues them with apparently universal truth. Accepting reification without question can lead people inside the boundary into organisational myopia (Nooteboom 2003) and cause them to reject alternative possibilities. The rejected alternatives can sometimes include the larger purpose for which the organisation was formed and its boundaries drawn.

Even when social processes are recognised as such by researchers and writers, they often still adopt from a relatively instrumental perspective when analysing the outcomes of efforts to improve the organisation, coordination and effects of clinical work through improved team working. For instance, despite acknowledgement that relationships and

processes within the NHS cannot escape pervasive gender disparities in work and social life (Griffin 2001; Öhman, Hägg, and Dahlgren 1999), one study (Sibbald, Shen, and McBride 2004) explained these away, arguing that the continuance of traditional clinical work practices was simply the outcome of lifetime workforce participation rates and the associated costs of doctor-nurse substitutions, apparently without recognition of the gender issues implicit in these phenomena. A similar tendency to reduce complex social effects to relatively instrumentalist concerns can be seen amongst authors concerned with the more overtly political aspects of the NHS. Particularly relevant here are analyses which see the persistence of relatively poor coordination in care between organisations and professions as a result of the efforts of powerful interests to retain their benefits from the existing arrangements within the healthcare system (Hunter 2004). Such analyses can lead to conclusions along lines that the Department of Health maintains 'tight central control and constraining micro-management of the service' by 'dictating the minutia of everyday activities of NHS staff' through 'a plethora of complicated targets and initiatives' (Bradshaw 2003; Smith, Walshe, and Hunter 2001) whilst generally purporting to support a coherent approach to local autonomy.

More overtly social explanations for the persistence of a lack of continuity and coherence in care planning and delivery have been sourced in (inter)professional issues particularly differing professional cultures and values (Degeling, Kennedy, and Hill 2001) (Degeling, Macbeth, Kennedy, Maxwell, Coyle, and Telfer 2002; Marshall, Mannion, Nelson, and Davies 2003; Neuhauser 1991) and associated entrenched attitudes to change within the health professions (Gale and Curry 1999; Gough and Richards 1999). The medical profession in particular is frequently accused of being inflexible and acting in self interest to maintain differentials in power, status, autonomy, and regulatory disparities in its favour (Atkin and Lunt 1996; Audit Commission 1992; Browne 1997; Herk, Klazinga, Schepers, and A.F. 2001; McLaughlin 2001). This power differential is maintained in part by traditional mono-disciplinary training and the history of separate professional development which create and maintain expectations of distinctions in professional domains, roles and authority, and limit understanding between professions (Lewis, Tudor, Tsao, and Canaan 1998; West and Slater 1996).

This combination of ignorance and presumption leads to disagreements and uncertainty between and within professions concerning role perceptions, work practice patterns etc (Castledine 1995; Dahle 2003; Richardson and Cunliffe 2003).

Few authors, including those cited above, attribute failure to achieve the expected changes to individual causes requiring individual solutions; they acknowledge that the maintenance of the status quo is a product of a multiplicity of factors that, working in combination, stymie change. The above discussion suggests that the various reifications and 'boundary issues' in healthcare, whether social or instrumental, define professionals' work identities, shape their roles and expectations, influence their judgements about the 'right' and 'wrong' way to be/do their job. Thus they present differences and divisions as natural and the current way of working as right and rational. Differences and boundaries are unavoidable in a society built upon the division of labour, and they are necessary for defining areas of expertise, but they can be antithetical to achieving work practice change and effective teamwork.

In the light of this complexity and the tendency towards stasis rather than effective change, I felt I needed to explore more deeply why *this* particular change effort, the Clinical Management Development project, in *these* particular Trusts had such seemingly different outcomes. I believed I needed to consider potential influences closer to the project itself as well as those lying more distantly in the wider context to identify influences worthy of deeper study. I framed my approach from within the perspective of organisational studies and more narrowly (though not exclusively) from organisational writers using a social constructionist approach. The field of organisational studies draws upon literature from many academic disciplines including sociology, social psychology, business management, policy studies, and economics, amongst others. In studies about healthcare organisations, the health professional literatures are also relevant. This is evident in the following discussion of the various foci and themes I considered in framing my research inquiry.

Organisational theory

Organisational theory largely views common difficulties in improving organisational performance and/or implementing change within individual organisations across a whole sector of economic activity as an outcome of institutionalisation. It is defined as the "emergence over time of orderly, stable, socially integrating patterns out of unstable, loosely organized, or narrowly technical activities" (Broome 1990) p238). A systematic review (Bailey and Bristow 2005) of 50 studies of factors influencing health sector organisational performance found that these organisations' performance was dependent upon a complex amalgam of organisational variables including structural arrangements, culture, technological capability, clinical reputation, quality of staff, strategic relationships, Trust strategy, and operational capability.

For better or worse, the distinctive forms, processes, strategies, outlooks and competences that emerge in response to these internal factors and to the shared external environment (Selznick 1957) shape and structure both what is possible within organisations and what is not (Giddens 1976; Giddens 1977). Over time, as organisational members come to understand these limitations and possibilities, and adapt themselves to them, they find it more and more difficult to think or act differently to those around them. What is seen, known, accepted and valued in organisations thus also becomes a way of not seeing, of not knowing or doing. When the environment changes and an organisation is required to adapt, the processes of institutionalism hinder corrective actions which may touch on key issues, significant values or the established network of norms and interdependencies, making the organisation hostage to its own history (Selznick 1957). Understanding how values, understandings and practices are built into the organization's culture, cognition and social structure, how these might be weakened or subverted, and the consequences of doing so, can therefore become critical in understanding the adaptability and long term viability of organisations. Organisational theorists take various approaches to this. 'Micro' and 'meso' theorists focus on the contributions and reactions of individuals and groups in these institutionalising processes. Others take a wider perspective looking at the agency and actions of other institutions in the wider environment in creating institutionalism.

Psychoanalytic and Relational Perspectives

Social psychoanalytic and relational perspectives approach these in terms of people's unconscious world and their expression of emotions. Their concern is how people think, in particular, how they construct identities to "make sense of other people and themselves" (Fiske and Taylor 1991; Maccoby 2004), how these identities create persistent tendencies to feel and behave in a particular way toward something (Luthans 2002), or manifest (or not) emotional intelligence (Goleman 2000; Salovey and Mayer 1990) in the workplace. Cognitive abilities are critical in two respects. At the level of an individual they influence the development of self-identity, linking identity to the person's environment (which for organisational purposes may be their workgroup (Ashforth and Mael 1989), their profession (Ibarra 1999) or the wider organisation (Dukerich, Golden, and Shortell 2002), and influencing their behaviour in the process. Secondly, the consequences of individuals' emotions, attitudes, thought patterns and behaviours reverberate throughout all organisational groupings (teams, work groups, professional bodies, interdepartmental relations) and activities (Turner 1987), affecting both self- and group- motivation, social identity, interpersonal relations, and the definition of acceptable roles and norms.

Empirical investigations have demonstrated that people tend to adopt 'miserly cognition' approaches when making assessments and decisions. That is, rather than making decisions based upon careful collection and analysis of data, people use pre-existing mental structures or schemas to guide their analysis of the environment and derive their conclusions. They tend to select their schemas as early as possible when structuring information, usually on the basis of visual and physical cues about which are the most relevant schemas. When given 'specific' evidence, they will ignore statistical probabilities and information biases that may challenge their existing categorisations, often despite considerable pressure (Kahneman and Tversky 1973; Tversky and Kahneman 1981). In situations of threat, the preference for miserly cognition habits can lead to escalation of dysfunction and conflict due to the tenacious maintenance of illusions (Taylor 1983), counterfactual thinking (Roese 1997), and escalating commitment to established positions (Staw 1976; Staw, Sandelands, and Dutton 1981).

Emotions, "strong affective states that interrupt cognitive processes and/or behavior" (Morton, Billings, Hankinson, Hart, Nicholson, Rowlands, Saunders, and Walter 2003), are another mechanism which may affect facets of organisational life. Collins (Collins 1981) suggested that it is these affective states, more than cognitive processes, that guide the interlocked cycles of behaviour in organisations that produce social structures. For him, people follow routines and behavioural cycles because they 'feel right'; the associated emotional dynamics of 'joining in' provide feelings of belonging, of connectedness, and other positive effects. The human relations school (Mayo 1933; Roethlisberger 1941) believed that the correct alignment of tasks, control over one's own work etc. produces job satisfaction, productive work attitudes and a healthy emotional life that is beneficial for organisational performance, and vice versa. However Collins' work suggests that it is not the relationship of people to their environment that matters but their relationships with each other. Thus the critical factor in organisational design may well be how the arrangement of tasks, roles and other operational components impact upon the affiliative dimensions of organisational life (Goodman, Ravin, and Schminke 1987). Hence the way in which teams, groups, committees etc. work can have an important bearing on how an organisation functions and on the outcomes of that functioning.

Teams and Teamwork

Initially, examining team work between care providers in the two Trusts appealed to me as it directed attention to the level at which clinical work is done. An extensive literature exists on teams, most of which is in agreement about their general benefits, their usefulness in promoting and managing change, and also their limitations. The business literature associates teams with high levels of productivity, quality, customer satisfaction, safety, job satisfaction and organisational commitment (Kirkman, Tesluk, and Rosen 2001), arguing that integrating different professional perspectives, competencies and contributions enables teams to be flexible, innovative, responsive and efficient (Mohrman and Mohrman 1997).

Definition of team

'Team' is an amorphous concept – few people, including those in the health-related academic literature, define what they mean by it (Drinka and Clarke 2000). In practise, teams in healthcare can be very simple, small and operate in close proximity or large, complex and geographically dispersed. They can be recently formed with short term purposes (as in project teams) or well established with long term goals; provide complex ongoing care or administer 'one off' diagnostic tests (e.g. x-rays, pathology tests); contain only specialists or be comprised of generalists; and have members from one or many disciplines. Finally individual team members may belong to only one team or to multiple teams. Faced with such an array of possibilities, Drinka and Clark concluded that defining a work group as a 'team' is misleading if it is not accompanied by a specific definition.

Definitions of 'team' range from the very simple dictionary definition, "people who depend on each other to some extent to get their work done", to highly defined concepts that go beyond the team itself to include the structural elements required to create effective teams. These usually specify a (small) number of people, working in a coordinated and collaborative manner over an extended period of time. They have complementary and overlapping skills exercised towards a shared and organisationally sanctioned purpose, who identify as a collective, and who both hold themselves mutually accountable for the team's results or outcomes (Manion, Lorimer, and Leander 1996) and, in turn, are held mutually accountable by superiors for their contribution to the organisation's objectives (Brill 1976); (Redman 1996; Shonk 1992) (World Health Organization 1984). In addition, teams, especially multidisciplinary teams, create synergy such that their collective workings and outcomes are greater than that which could be achieved by members working individually, by one discipline working alone or by many disciplines operating in sequence (Colenso 1997; Pence and Wilson 1994). The benefits for patients with long term conditions (who tend to require treatment and assistance across a multiplicity of needs, physical, social, emotional, educational and spiritual amongst others, over an extended time span) have received particular, focused attention. These teams have been found to meet patients' multiple needs in an appropriately harmonised, coordinated fashion (Loxley 1997; Payne 1982),

providing increased continuity and consistency of care through holistic discussion, better planning, enhanced problem-solving and reduced ambiguity between team members (Birleson 1998; Proctor-Childs, Freeman, and Miller 1998).

In general, any conception of healthcare teams usually assumes that members work alongside other team members at the same time and in the same space, at least for scheduled portions of time, even if that is only for certain hours of the week, such as in case discussions or discharge meetings. In practice however, such teams are often the exception rather than the norm. Research in Sweden suggests that, within hospitals, clinical staff often come together in fluid, temporary and unstable combinations as the need arises. Action in these 'teams' can be characterised as a "rapidly pulsating, distributed and partially improvised orchestration of collaborative performance between otherwise loosely connected actors and activity systems" (Engeström, Engeström, and Vähäaho 1999). Though such work is commonly described as teamwork, the researchers suggested that the ephemeral nature of these interactions is not teamwork but 'knot working'. This concern for *how* staff actually function together, however, is lacking in much of the 'team' literature.

Team Context

Others have different caveats about the operation of teams in healthcare. Jayasuria and Sim (Jayasuriya and Sim 1998) and Mickan and Rodger (Mickan and Rodger 2000c) argue that the context and goals of teams in (publicly funded) healthcare differ widely from the manufacturing, IT and commercial service industries' contexts, from which most literature on teams and teamwork emanates (including the newer formats of virtual and self-managed teams). They believe the unique end goals and outputs of health care (treated patients, improvements in quality of life, cure) are qualitatively different to the more profit oriented industries. This seems somewhat unreasonable given that many service industries' goals and 'products' are also experiential and could be said to be primarily about 'quality of life'.

Perhaps more powerful are their arguments that health care teams are unique in their need to balance and contain the powerful and competing influences of professionals

within and alongside public sector health care. Some factors create difficulties in team performance regardless of industry or sector. For example, poor or missing supportive organisational structures, unclear tasks and inappropriate leadership (Mohrman and Mohrman 1997), power differentials and conflicting loyalties within the team (Payne 1982), internal competition, coercion, abuses of personal power, pressures to conform, adopt particular personas and/or exhibit a limited range of behaviours (Brill 1976; Firth-Cozens 1998; Kane 1975; Raines 1988)). However specific factors additionally impede teamwork in healthcare. This is due, in large part, to different organisational structures and processes in healthcare, particularly as they relate to issues of professionalisation, relationships between senior management, middle management, the 'shop floor' and teams.

Most public health care organisations are organised vertically into what are effectively hierarchical silos (Degeling, Maxwell, and Iedema 2004; Horwitz 1970; McNulty and Ferlie 2002). Multidisciplinary teams do not fit easily into these silos because they include people with differing professional values, power, and breadths of organisational responsibility. Such team members, both individually and corporately, frequently have multiple responsibilities with different required standards of practice and multiple, often inconsistent, accountabilities (Brandis, Murtagh, and Solia 1998; Firth-Cozens 1998; Headrick, Knapp, Neuhauser, Gelmon, Norman, Quinn, and Baker 1996). In hospitals, matrix management structures such as clinical directorates are ideally meant to bring clinical professionals together in joint responsibility for the corporate governance outcomes of their work, especially cost. In clinical directorates the clinical 'team' (medical, nursing, and allied health professions) frequently have simultaneous loyalties and responsibilities to a hierarchically arranged clinical department, a relatively 'flat' external professional structure such as a medical royal college, and both specialty-based and multidisciplinary teams. Furthermore, team members are expected to work in additional 'teams' with managers, administrators and sometimes even scientists. With such diverse working relationships, complex accountability relationships and potential conflicts, it is perhaps not surprising that clinical directorates have struggled to achieve the goals mooted for them in health related organisational and management literature. Organisations with clinical directorates frequently do not demonstrate either

integration of clinicians into management or effective multidisciplinary team functioning around the process control of their work. Rather, they commonly simply replicate the previous organisation of clinical work (Braithwaite 1999) and struggle to overcome medical dominance in decision making (Hearnshaw, Reddish, Carlyle, Baker, and Robertson 1998; Horwitz 1970). Moreover, they increase complexity (Pich, Loch, and De Meyer 2002; Plsek and Wilson 2001), create blurred boundaries and uncertain power relationships (Mickan and Rodger 2000b), and fuel tension between those professionals subject to greater and lesser professional autonomy and associated flexibility in work practices (Abelson, Maxwell, and Maxwell 1997).

Alongside this is the fact that participants in teams with strongly competing interests may have dissimilar conceptions of how teams should be structured. In addition to the diversity outlined above, for instance, teams can be structured traditionally (focused upon their internal dynamics) or openly (focused upon outward relations and networking) (Payne 1982); be hierarchically- or self- directed (Blanchett and Flarey 1995); and function coordinatively or integratively. (Coordinative teams are comprised of separate professionals with their own roles and professional hierarchies who nonetheless are influenced by each others' ideas whilst integrative teams have members from different professions who share responsibility and work roles such that information, knowledge and skills are transferred across their professional boundaries with members frequently taking on roles associated with each others' disciplines) (Garner and Orelove 1994; Ovretveit 1997).

The changing healthcare environment adds further complexity to these already complex work relations. The increasing expectations for patient, family and public involvement in wider decision making, for example, have a specific expression in expectations that the families of children with learning disabilities or patients with long term medical conditions be active and equal contributors in early intervention teams spanning health and other environments (education, social care, employment, even housing and transport). However, as noted above, multidisciplinary teams are frequently characterised by an already precarious power (im)balance. The addition of patients and families, whose contributions may be widely variable, extremely

knowledgeable and competent in some areas but far less so in others, increases the combinations and potential for conflictual relations within the team (Maple 1987). Furthermore, attempts by doctors to adapt to this flexibility by working in a more egalitarian and interdependent manner may lead individual doctors to risk fragmenting medical knowledge, fall foul of their colleagues' professional values and interests, and exacerbate pressure for ongoing dynamism and renegotiation in team structures, roles, and responsibilities (Cott 1998; Horwitz 1970). This further contributes to confused expectations about the expected pace of work and accountability for teamwork (Loxley 1997; Maple 1987; Qualls and Czirr 1988). Apart from the obvious potential for conflict within the team, this may also result in the patients' needs being subjugated to the internal politics of professional power and conflicting messages from team members, at moments when patients (and their families) are least capable of dealing with ambiguity (Kane 1998; Mickan and Rodger 2000a).

Clinical work and executive teams

Interestingly, discussions on team work in the health related literature have focused predominantly upon team work at operational levels. There is relatively little about the functioning of the "executive team" although there are several studies about the operation of the Trust boards (see for example (Hackett and Spurgeon 1996; Mueller, Harvey, and Howorth 2003; Mueller, Sillince, Harvey, and Howorth 2004)) and many more about 'senior management' (variously and usually loosely defined). Some who have considered the role of the executive in the functioning of teams, even if obliquely, have argued that the executive is not a team at all. Manion et al (Manion, Lorimer, and Leander 1996) and Iedema et al (Iedema, Meyerkort, and White 2005) for instance have argued that the executive level of health care organisations usually comprises working parties or committees in which each senior manger coordinates his/her own individual areas of responsibility with others rather than being jointly accountable across the entire executive. Both argue that, unlike teams which directly control the outcomes of their work in a fluid and dynamic manner, the top management 'team' is dependent on others to achieve their objectives. As earlier discussion has suggested, in organisations such as the NHS which are comprised of a series of professionalised bureaucracies, the compliance of others in achieving the executive teams' goals cannot

always be assumed (Mintzberg 1989). Also, unlike teams, senior managers are not free to self-define their work, changing foci, responsibilities, constitution and tasks as they learn more about themselves and their tasks. Others however, perhaps using 'team' more loosely, have argued that the long term future of the NHS depends on the local leadership capacities and an extremely high order of skill and expertise in local executive teams (Berwick, Ham, and Smith 2003).

Disputes about the nature of the executive group aside, few would argue that there has been little study of how a Trust executive conceptualises clinical work and its performance. It seems there are several unquestioned assumptions on the part of both academics and the health service regarding the executive's role and responsibility for clinical work. These are that clinical work performance management is the prerogative of clinicians rather than management, that any corporate responsibility to oversee clinical work is met adequately by existing clinical governance structures and committees, and that meeting external performance targets and passing external inspections equates with system optimality. Perhaps more importantly, despite myriad acknowledgements in published papers on team and clinical practice change that "the support of the senior management was sought", there is next to nothing about what this means in practice or about how, if at all, the effectiveness of the executive 'team' relates to the effectiveness of clinical teams and vice versa. Some (limited) work on this in Australia (Maxwell, Degeling, Sorensen, Zhang, and Coyle 2007) found that, when it came to thinking through how clinical work can be better organised and managed, the effectiveness of both clinicians and senior management were, to some extent, mutually limiting. This was attributed to, firstly, a poor definition and understanding of the role and potential of clinical managers by clinicians and managers at all levels and, secondly, by the inability of both managers and clinicians to envisage an alternative way of doing things. In an extension of this work, Sorensen (Sorensen 2002) found that hospital performance was better in hospitals in which management had a clear method for clinical work management, (clinical) team-based incentives to direct and reward effort, and inclusive strategies for change. How executive teams achieve an agreed model for clinical work management between themselves and with clinicians, and

effectively motivate and reward clinical teams in a professionally and politically complex environment, however, has not yet received attention.

In the light of this, I decided that focusing attention on the operation of clinical teams within the two Trusts may be extremely helpful but could result in me seeing the trees and missing the forest. It would be however useful to consider how the executives in both Trusts conceptualised clinical work and its management and, if this was coherent, whether this view was disseminated throughout the organisation. This led me to also consider more theoretically 'macro' level attributes of organisational institutionalism.

Leadership

Definition of leadership

Leadership, the ability to inspire, persuade, develop and empower followers (Addicott and Atun 2003; Yukl 2002; Zaleznik 2004), has become a very popular explanation for superior and/or improved organisational performance over the last 50 years or so in the commercial, business and, more recently, healthcare press. It is seen as critical during times of organisational stress and required change (Day 2001; Kotter 1996) particularly in response to environmental pressures such as increased competition, changing preferences by consumers, and increased regulatory control (Kotter 1990; Kotter 1996; Kotter 2001). Yukl (Yukl 2002) suggests that leadership is often confused with concepts such as power, authority, management, administration, control and supervision. He argues that these wrongly imply domination, compliance and obedience rather than the winning of 'hearts and minds' about what needs to be done and how it can be done effectively, and the voluntary offering of willing and collective support to accomplish shared objectives. Much of the literature on leadership originates in, and reflects the culture of, the United States of America. It is characteristically casts the 'leader' as an heroic individual leading from on high; possessing skills and abilities beyond those with whom the leader works; bending organisational cultures, structures, people, processes and practices into an exceptional coherence, competency, capability and achievement through the sheer force of his (rarely her) brilliance and vision.

At the same time (and somewhat paradoxically) it also implies that leadership is a tool or technique that can be learnt and applied stepwise if one simply adopts the right personality traits, personal qualities, tactical behaviours (Allport 1937; Bass 1990; Bennis 2003; Stodgill 1974) and skill competencies (Goleman 1998; Tarplett 2004). 'Good' leaders, adopt a 'transformative' relational style which is characterised as being visionary, proactive, creative, innovative and supportive of alternate viewpoints (Empey, Peskett, and Lees 2002). They apply these behaviours to 'manage meaning' within an organisation by defining an organisational mission, promoting an organisational vision, endorsing preferred practices and enacting desired values (Bass 1985; House, Spangler, and Woycke 1991; Westley and Mintzberg 1989). Transformative leaders are thought to be outside organisational culture, comfortable with conflict (often finding it creative, empowering and change enabling), lead from a desire for something better, to inspire loyalty and to take risks (Zaleznik 2004). Such leaders however need not be flamboyant or malignant (Conger 1988; Hogan, Raskin, and Fazzini 1990; Mintzberg 1999); effective leadership can be humble (Schein 1985), servant based (Greenleaf 1970; Greenleaf 1996), and again somewhat paradoxically, shared (De Marco and Lister 1987) or distributed throughout the organisation (Alimo-Metcalfe and Alban-Metcalfe 2004; Gronn 2002).

Leaders are frequently juxtaposed with mere managers who are believed to be supporters of the organisational status quo, seekers of stability and control who instinctively try to solve problems quickly – sometimes before understanding the problem's significance. They are believed to operate out of necessity rather than from heartfelt desires and to be good at defusing conflicts in order to get the day to day things done. They tend to diffuse power by favouring forms of bureaucratism, emphasising structures, due process, incremental thinking, and cohesion through rule keeping. They are strong on technical knowledge and knowing how each layer of the organisation works; they use rationality, functional methods and good relationships with staff to achieve stability (Bryman 1992; Goleman 2000; Kotter 1990; Yukl 2002; Zaleznik 2004). In practice however the roles of leaders and managers overlap: effectively led organisations are not characterised by division and poor staff morale,

instability, an absence of due process, ill fitting operational structures, poor functionality, and a lack of inspiration and purpose.

Leadership in the NHS

Smith and Fiori (Smith and Fiori 1989) argued that any advance in leadership theory and understanding must involve simultaneous (and complex) consideration of the leader's characteristics, behaviour and context. In healthcare there is a longstanding distinction between the leadership of the CEO (and/or his/her team of directors) and clinical leadership (Firth-Cozens and Mowbray 2001); usually in the form of a profession and mostly, but not always, doctors. However, Firth and Mowbray note that clinical leadership can also include leadership of multidisciplinary teams and thus is distributed throughout the organisation. Zaccaro and co-writers (Zaccaro, Rittman, and Marks 2001) noted that, despite the ubiquity of leadership influences on organisational/team performance and the large literatures on leadership and team/group dynamics, surprisingly little is known about how leaders create and handle effective teams. Further, little attention is paid to the reciprocal influence of leadership and team processes upon each other. Taken together with the increasing pressure to involve clinicians in management at senior levels, these factors create an extremely complex context for NHS executive teams. Moreover, the larger the executive team, the greater the potential for conflict. This conflict need not necessarily be destructive however. A study of 48 effective top management teams (non-health based) noted that effective executive teams engage in cognitive conflict (task-oriented disagreement arising from differences in perspective) but limit affective conflict (individual-oriented disagreement arising from personal disaffection) and also promote this style of relating throughout the organisation (Amason and Sapienza 1997).

Despite this care by some to distinguish between types of conflict and modes of personal operation in senior management teams, much of the leadership literature still adopts a relatively simplistic means-ends conception (Degeling, Iedema, Winters, Maxwell, Coyle, Kennedy, and Hunter 2003a). This preoccupation was evident in the NHS Modernisation Agency's and related organisations' literature which consisted principally of extensive listings of tools, techniques and competencies, primarily

(although not exclusively) to develop the quality of leadership within small clinical teams; see for examples (Centre for Diversity and Work Psychology 2004; Clarke, Bailey, and Bristow 2003; Hartley and Hinksman 2003; NHS Leadership Centre 2002; Williams 2004). Whilst of a high standard of presentation, the Agency's and related publications promoted leadership as a solution to NHS organisational ills without first being clear what those ills were, why they existed, and what sustained them. They did not address fundamental questions at the core of the academic debates around both leadership and the NHS – leadership by whom, of who, for what purpose, in which context, and around and within which structures. An interim review of the relative contributions of legacy, luck and leadership to NHS organisational performance (Bailey and Bristow 2005) purported to begin to address these questions. The report writers argued that their proposed model, by treating organisational performance as a feature of an organisation rather than of an individual, enabled them to ask "enlightening questions" about who contributes, and how, to the leadership of the organisation, and what roles specific groups or teams play in the leadership of Trusts. However it is not evident how the model enabled this nor is the final report available to comment on its adequacy or revelations.

Calls for leadership in the NHS often seem to be a means for implicitly obtaining the elusive but highly desirable goal of 'clinical engagement', a vague term that appears to have evolved over time. In the 1980s and early 1990s clinical engagement was seen as hospital doctors becoming more accountable for the financial aspects of their work, however, the incoming Labour government in 1997 greatly expanded the term. Under the new regime clinical engagement initially meant asking doctors, nurses and allied health professionals in primary care, through (medically led) Professional Executive Committees of new primary care groups and Trusts, to take leadership and responsibility for developing health improvement plans for their local communities. Thus clinicians were meant to make investment decisions about where and how services should be provided. Later the term meant a much greater involvement of healthcare professionals in reshaping how clinical services are provided in hospitals.

As earlier discussion noted however, multidisciplinary leadership is problematic in organisations plagued by entrenched differences between professional bureaucracies. Grint (Grint 2000) and others argue there can be no leaders without followers; the relationship between these two requires a sense of community and mutuality and that leaders must, to some extent, also be followers if they are not to lose their social authority (du Pree 1993). Hence the leader's exercise of authority is always conditional and in need of constant reaffirmation in the dynamics and actions of the relevant communities of practice and institutional authorities (Degeling and Carr 2004; Wenger 2000). But healthcare managers and leaders of individual clinical communities are often not accorded widespread authority amongst staff from other professional disciplines, even within the one organisation. Leadership, especially multidisciplinary leadership, within the NHS therefore frequently remains highly contested (Degeling 1993b; Edwards, Marshall, McLellan, and Abbasi 2003; Ham and McIver 2000; Ham and Hunter 1988; Harrison, Hunter, Marnoch, and Pollitt 1992a; Marnoch 1996; Piper, Muir, A, and J 1997; Pollitt, Harrison, Hunter, and Marnoch 1988).

There are additional absences in the academic leadership literature in relation to the NHS which raise important (unanswered) questions about the potential for leadership to effect change. Firstly, with some key exceptions, most notably Beverley Alimo-Metcalfe and John Alban-Metcalfe (Alimo-Metcalfe and Alban-Metcalfe 2004; Alimo-Metcalfe and Alban-Metcalfe 2005; Alimo-Metcalfe and Alban-Metcalfe 2006), there is a relative dearth of leadership theories and research relating to public healthcare in general and the NHS in particular. A growing consensus exists that the NHS needs 'local leaders' but there is as yet little consensus about what this concept looks like. Secondly, there are relatively few articles about leadership in medical journals and relatively few doctors who are CEOs of NHS organisations. What is the significance of this? Are doctors just not interested in organisational leadership as some studies seem to suggest e.g. (Forbes, Hallier, and Kelly 2004), at least in a significant number of cases? Do doctors just 'assume' a mantle of leadership amongst their colleagues or nurses by virtue of traditional medical status and power and see no need to discuss it? Or do doctors consider themselves so autonomous that leadership is a contradiction in terms for them? Further, critical theorists would say that doctors have always been

engaged in the NHS, just not with others' agendas; hence much 'leadership' and reform is aimed at de-empowering them and empowering others, and is consequently ignored and resisted by doctors.

Thirdly, there is a relative abundance of writings on leadership within nursing literature and specific nurse leadership training programmes yet they are relatively under represented in organisational and policy debates. This suggests that nurses are highly aware of their traditional subordination, that leadership development is more integral to the wider nursing agenda than medicine's, and that nurses are working strenuously to overcome their weak power base. Evaluation of the three year Leading Empowered Organisations (LEO) training scheme, however, revealed that this programme was relatively ineffective in creating changes in both nursing and organisational practices due to the significant personal, organisational and wider contextual factors operating to disempower nurses (Hancock, Campbell, Bignell, and Kilgour 2005).

The literature on leadership would also imply that the *quality* of NHS leadership is to blame for persistently poor progress in improving the coordination of care – too much 'transactional' leadership and too little 'transformative' leadership leaves the status quo relatively unchanged. However the context can be extremely unhelpful to the development of transformational leadership: it is difficult for CEOs and senior managers to chart their own course in a highly centralised and politicized network of organisations held together by (amongst other things) a socialistic belief in the common good, government obligation for the welfare of the community, and government-sponsored monopoly of organisations and profession. Despite the movement towards Foundation Trusts and their supposed freedoms, and the pressure for Trusts to become more competitive and commercially viable, few political (or other) players have argued that the foundational values and professional structures of the NHS need to change. Indeed the opposite is usually the case. Whilst requiring better managerial performance and accountability, successive Labour Secretaries of State for Health, from Dobson to Johnson, have echoed (though perhaps less loudly) Bevan's commitment to the primacy of the professions, particularly the medical profession. This established inequality in power relations between professions represents, if not a

natural limit on the reach of 'leadership' (however defined) within NHS organisations, then at least an often vexing constraint.

But change needs to begin somewhere, and having begun, needs to be appropriately supported and managed. Leadership within the Trusts therefore seemed to be relevant to my question and could not be ignored; however, I was skeptical about how fruitful an avenue it would prove as a focus of investigation in isolation from other considerations.

Culture

One cannot fully understand how a leader (whether an individual or group) acts without an understanding of the relationships between culture and the people who both shape and are shaped by it. While debate continues regarding the extent to which culture enables or constrains an individual's leadership ability, and the degree to which culture itself can be influenced by 'the leadership', the fact remains that effective leadership occurs within the context of a particular culture or cultures. The management literature on leadership therefore almost inevitably also discusses the impact of organisational culture and promotes particular forms of it, whether a 'quality' culture, a 'learning' culture, or something else. Hence in much of the leadership and management literature, culture is assumed to be an instrumental concept, an organisational attribute that is malleable in the hands of the leader, in support of enhanced organisational performance.

Understanding culture

An analysis of the literature reveals a plethora of definitions of organisational culture. One key definition was provided by Schein who described organisational culture as "a pattern of basic assumptions - invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration - that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems" (Schein 1985), p 9). This collective construction of culture suggests that culture is best viewed as part of a system, a social process, something that is experienced, lived and reproduced (Smircich 1983). In the words of Marvin Bower (Bower 1966), culture

controls the informal but still often sacrosanct aspects of organisational life, "the way we do things around here". These informal aspects of organisational life are manifested in the prevailing norms, dominant values (learned and inherited), 'rules of the game' (accepted behaviours and practices), feelings and 'climate' within an organisation, and in the philosophies and paradigms underlying thinking, decision making and action taking. They are displayed in "characteristic ideology, language, dress codes, behaviour patterns, signs of status and authority, modes of deference and misbehaviour, rituals, myths and stories..... and unspoken assumptions of a group" (Scott, Manion, Davies, and Marshall 2003), p1).

For cognitive theorists, culture is essentially a system of knowledge or learned standards that structure perception, belief and evaluation in ways that enable individuals to act acceptably to other group members (Goodenough 1971). For symbolic/semiotic theorists and sociologists, culture is perhaps more subtle, hidden in the symbols and understandings shared by social actors. Both groups, however, argue that, as a result of the unique combination of its origins, history, socio-cultural context, technology, and successive leaders, an organisation may evolve and sustain its own culture, its own system of symbols and meanings that elicit the commitment of staff to the organisation (Allaire and Firsirotu 1984). The 'core' or essential values of this binding culture however will not be visible or known to the participants for they "operate unconsciously ... in a basic "taken-for-granted" fashion(ing of) an organisation's view of itself and its environment" (Schein 1985), p 6).

Because these values are covert, hidden and invisible even from people inside the organisation, staffs' explanations of their actions to external audiences or even to themselves, their 'espoused theories' of action, may be incongruent with their theories-in-use i.e. what they do (Argyris and Schön 1978). (Self aware) newcomers however will often recognise, through the responses of others, when they have transgressed an unseen cultural norm. Often this is because the norm is based upon ideal patterns of behaviour which members of the culture hold as highly desirable, even if they seldom practise it. Longer term organisational members will be able to tell the newcomer *that*

they have offended the norm, and could explain even *what* that norm is, but would probably be hard pressed to justify the basis and existence of the norm.

Organisational culture and performance

Hence much of the behaviours, espoused theories and theories-in-use in organisations are 'tacit knowledge' (Polanyi 1958, 1998). Such tacit knowledge includes unrecognised (and perhaps, if recognised, publicly unacknowledged) assumptions about the self, others, the situation, and the connections amongst action, consequence and the situation (Argyris and Schön 1974). As a result, one cannot assume that one understands any individual's or professional group's 'theory-in-use' and how this drives their individual behaviour by observation alone; one must somehow 'get inside someone's skin' to access this level of understanding (Bartol and Richardson 1998). Hence, on one level, understanding an organisational culture requires somehow identifying and making sense of a vast complexity of overt and covert, individual and professional, histories and stories. It further entails identifying the dynamics by which they intertwine, complement and compete with each other to create "the way things are done around here". This not withstanding, it is often possible to identify key practices and perceptions within a particular culture; this possibility has led to an interest in 'tweaking' or 'improving' NHS culture to enhance organisational performance regarding service delivery, patient outcomes and public satisfaction. NHS staff have consequently become familiar with calls for a 'no blame', 'performance enhancing', 'patient centred' and 'improvement oriented' cultures (Campbell, Sheaff, Sibbald, Marshall, Pickard, Gask, Halliwell, Rogers, and Roland 2002; Department of Health 2000; Peck and Crawford 2004).

Some attempts to provide a robust metric for this mooted relationship between culture and performance have suggested that healthcare cultures which emphasise group affiliation, teamwork, and coordination are more likely to be successful in implementing work changes oriented towards ongoing quality improvement and health outcomes (Shortell, O'Brien, Carman, Foster, Hughes, Boerstler, and O'Connor 1995; Shortell, Jones, Rademaker, Gillies, Dranove, Hughes, Budetti, Reynolds, and Huang 2000). In the main, however, authors have found that whilst organisational culture may be a

relevant factor in health care performance, articulation of the nature of the relationship is difficult; interactions between culture and performance, if any, are indirect (Davies, Hodges, and Rundall 2003; Dowswell, Harrison, and Wright 2001; Scott, Manion, Davies, and Marshall 2003; Scott, Mannion, Davies, and Marshall 2003). Accepted understandings about organisational culture and performance assume that the primary work groups within organisations contribute complementarily to the larger organisation's purpose. That is, they assume the circulating stories, prevailing myths, accepted codes of behaviour and established rituals within subgroups bring people together in a value-infused institution glue (Boje and Fedor 1982; Deal and Kennedy 1982; Harrison 1972; Mitroff and Kilman 1976) which 'provides a sense of identity, promotes loyalty to something larger than the self and the small group' (Smircich 1983). The greater integration, the more corporate leaders can motivate workers into sustained work practice change and better performance (Bass 1990; Burns 1978).

However, as earlier discussion revealed, healthcare organisations are not typical hierarchically governed entities. In complex professionally based organisations, the multiple organisational professions, subgroups, subcultures and countercultures are likely to compete to define the nature of the organisation for their own ends (Brown 1954) (Scott, Manion, Davies, and Marshall 2003) (Selnick 1957). Further, the NHS is not a unitary organisation but a network of many smaller organisations, across various sectors, each employing staff from many different professional tribes, each of which has its own set of values and beliefs. These staffs are drawn from many educational, ethnic, religious, class and gender groupings, and their associated cultures. The sub-cultures of the NHS therefore are likely to be multihued, varying from locality to locality and group to group, depending upon the composition and interactions of its constituent staff. For these reasons, there is a pressing need to understand the individual work group cultures that comprise the larger organisation (Seago 1996) and to identify relevant conflicts in values (Ehrich 2006).

Research has shown that the health professions' different values, practices and approaches to 'care' impede staffs' ability to discuss clinical work across disciplines (Degeling, Kennedy, Hill, Carnegie, and Holt 1998; Degeling, Maxwell, Kennedy, and

Coyle 2003; Degeling, Hill, Kennedy, Coyle, and Maxwell 2000a; Degeling, Kennedy, and Hill 2001; Degeling, Sage, Kennedy, Perkins, and Zhang 1999). Staff tend to be more influenced by their professional perspectives than the objectives of their employing organisation. They have their own view of reality and their own way of doing things; they often take the stance that the other professionals in their facility are not only different but wrong; and they defend their own group from attack or threat from another group (Neuhauser 1991). Further, these professional cultures are particularly resistant to change. Their professional outlooks and loyalties persist across, and perhaps even replace, otherwise important local or national organisational boundaries (Degeling et al. 1998; Degeling, Maxwell, Kennedy, and Coyle 2003; Degeling et al. 2000a; Degeling, Kennedy, and Hill 2001; Degeling et al. 1999; Degeling et al. 2002; Degeling, Zhang, Coyle, Xuc, Meng, Quc, and Hill 2006). If then a particular organisation does noticeably better than others in creating change in work practices, and work practices are primarily the domain of individual professions and occupations, the possibility exists that the cultures of subgroups are better aligned in this organisation compared to others. This suggested that an examination of the subcultures within the two study Trusts in contrast to other Trusts would be a useful avenue for investigation.

Power

The role and impact of power (popularly understood as "the ability to get others to do something that they would not otherwise do" (Selznick 1957) and power contests in organisations are central to more critical interpretations of social constructionist understandings of organisations. In organisation theory, power is distinguished from authority although the two may coincide. Authority is legitimated power in which the right to control is vested in accepted entities. This implies that true authority has both social and legal facets which, in combination, are assumed (at least in western traditions) to make the exercise of power visible, accountable, less arbitrary and relatively efficient (Pfeffer 1981). When certain aspects of legitimated authority are held by some groups or individuals within an organisation and other aspects are held by others, the potential exists for contests about which group holds most power. This is compounded by the fact that functional and other divisions within organisations allocate

different goals and activities to subunits such as departments and teams, fragmenting staff and organisational interests (Morgan 1997).

Contestation and conflict about which groups and individuals hold most power can be quite destabilizing to an organisation, undermining its ability to achieve apparently desired goals. Much of the 'dilemma of reform' in the NHS revolves around the competing interests, power bases and status of the managerial cadre and the medical professions. The former have been charged with the difficult task of simultaneously meeting policy makers' requirements for greater hierarchical control and organisational performance through the use of targets, performance indicators and external inspections, whilst also accepting the rhetoric about the pre-eminence, expertise and special abilities of the latter in understanding healthcare. The struggle by both professions to fulfil expectations, and take the lead in setting the direction and operations of Trusts, can result in a deflection of organisational effort. Efforts to lead effectively became mired in the development of informal political coalitions, attempts to create resource dependency or independency, attempts to control the measurement of work through arguments about definitions, standard setting and form completion, the fostering of competing systems of reward and sanction (these need not necessarily be either financially based or punitive), and the setting up of structures designed to control knowledge, information, and decision making in an effort to both restrict others' access and reduce uncertainty for the power holder (Burns 1978; Cohen and March 1972; Hickson, Hinings, Lee, Schneck, and Pennings 1971; Strauss, Schatzman, Ehrlich, Bucher, and Sabshin 1963).

Status plays a significant part in this at both individual and group levels. High status strengthens and underpins a profession's claim to power and helps to entrench the power of the elite; people and professions of higher status will tend to be evaluated more positively by others, and people and professions of low status will not. People in positions and professions of low status therefore will find it difficult to challenge their place in the system and the system itself. This is demonstrated in the dominance and status of medicine over other professions, the dominance of specialists over generalists, and the seeming absence of nursing's voice in wider NHS debates. Whilst

authors within healthcare acknowledge, comment on, and at times deplore ongoing power struggles to amend, subvert or overturn entrenched status and power in the NHS, the level of acceptable, even desirable, 'creative tension' between professional groups remains a moot point (Davies, Hodges, and Rundall 2003; Degeling, Maxwell, Kennedy, and Coyle 2003; Edwards and Marshall 2003; Fitzgerald and Sturt 1992; Kenny and Adamson 1992).

One way of reconciling this situation is to accept that competing views and interests are a fact of life, there is often no 'right' way, and contestation is not always dysfunctional. Organisations with an ability to live with these inherent tensions and also to manage paradox, for example between the needs to innovate and to avoid mistakes, the needs to minimise cost and to produce high quality processes and outcomes, and the needs to be flexible and to respect the rules, may therefore be considered, on these grounds, to be successful (Morgan 1997). When a CEO and/or senior management team can do this, there is likely to be a widespread acceptance (if not necessarily quiescence) regarding hierarchical authority within the organisation and an associated greater acceptance of the prevailing structures within the organisation. There will be less resistance to the prevailing allocation of goals and resources, and greater willingness to Trust executive decisions, even when the executive seeks to introduce change. Subordinates are likely to want to maintain and enhance the executive team's power (since no-one wants to rock the boat), providing a mechanism for the senior team to continue to manage 'meaning' through effective two-way communication. This, in turn, strengthens the central leadership and fosters successful organisational change via the creation of a widely owned corporate vision, organisational cohesion and operational commitment (Stace and Dunphy 1994).

Abraham, Crawford, and Fisher (1999) argue that good organisational communication is central to creating and protecting these facets of organisational life. Good communication is inclusive in that people of all levels in the organisation can suggest ideas, give and receive feedback, and critique developments. It is also symbolic in that leaders and managers "walk the talk". By this they mean that leaders model the message and mission of the organisation in every organisational activity and practice,

including the realms of structure, policies, procedures, work practices, traditions, rewards, and management of internal and external relationships. In this way they begin to institutionalise new distinctive forms, processes, strategies, outlooks, competencies (Selznick 1957) and to create new 'taken for granteds' that shape and restructure what is becoming possible within the organisation and what is not. Sathe (Sathe 1985) and Vaill (Vaill 1993) have argued that 'talk', particularly about organisational vision and values, should be couched in imagery (depictions of heroes, metaphors, vivid pictures, stories and the like) as well as more ordinary forms of communication. Such imagery should be consistently woven into official communications such as inspirational speech making to groups, corporate publications, memos and slogans as well as personal intimate conversations with individuals.

Though I did not want to focus on the role and distribution of power in the two Trusts, preferring to focus more specifically on themes that would open up my thinking about the management of clinical work, I knew that it could not be ignored. I decided that I should be careful not to ignore how power and language were used in the Trusts and I should look for indications that common linguistic images and catch phrases, originating from the 'powerful' were being employed in pursuit of the Trusts' goals and desired change.

Organisational Change

An extensive literature has developed around organisational change management, especially in business-related literature. Much of this literature suggests that organisational change, including that relating to fundamental processes within an organisation, can be achieved quite successfully through careful planning and execution, such that the right methods are applied in the right order and in the right time frame. One review of organisational change in U.S. hospitals found that hospital change management projects required an overall strategy that linked all relevant factors and managed them simultaneously (Walston and Kimberley 1997). The main facilitators were: establishing and maintaining a consistent vision, preparing and training for change, planning smooth transitions, establishing multiple communication efforts, ensuring strong support and involvement, creating mechanisms to measure

progress, establishing new authority relationships, and involving physicians. Hence, extremely complex amalgams of interrelated and interdependent complexities, ambiguities and uncertainties (Baccarini 1996) (Pich, Loch, and De Meyer 2002) are approached in the literature in a very instrumental manner.

This instrumentalism has been severely critiqued on several fronts and often by well respected commentators, e.g. Pressman and Wildavsky's seminal analysis of public policy implementation failure in the US (Pressman and Wildavsky 1973), more recent criticism of change projects in large commercial organisations (Beer, Eisenstat, and Spector 1990), and McNulty and Ferlie's analysis of the failed Leicester Royal business process re-engineering project (McNulty and Ferlie 2002; McNulty and Ferlie 2004). (The latter focused on the reorganisation of care processes in a Trust believed to be a relatively well-performing organisation receptive to such techniques). Drawing on their experiences, these commentators and others noted that the multiple priorities and decision points in the change process, the resilience of existing cultures, and the 'defensive routines' (Argyris and Schön 1978) of staff groups to 'top down' change all impede the likelihood of success in (imposed) major change projects.

Taking a wider approach, DiMaggio and Powell (Di Maggio and Powell 1983) have argued that internal pressures for organisational innovation will usually be significantly outweighed by external pressures for conformity. Organisations are thus much more likely to change to become more like the industrial status quo, and thus each other, rather than less so. Innovations that go against industry norms and accepted practice are likely to be resisted in the face of governmental policies and regulations (especially those relating to regulations and external standard setting and monitoring), professional standards by other players such as auditors, pressures for risk minimisation etc from financial lenders, and other pressures for conformity with other institutions/organisations operating in the relevant field. In the case of the study Trusts, external pressures for conformity would include Departmental policy, centralised targets, guidance and directives from Strategic Health Authorities, contractual requirements with PCTs, care management, referral practices and patterns amongst general practitioners, and partnership arrangements with Local Government providers.

Despite a plethora of change initiatives in the NHS over the last decade and more, a recent systematic review of change management in service innovations in health service delivery and organisations (Greenhalgh, Robert, Macfarlane, Bate, and Kyriakidou 2004) found very few robust examples of successful, sustained major changes in the organisation of healthcare care delivery processes. As a corollary, it also found, no doubt to the chagrin of harassed NHS managers pressed to achieve swift, significant and sustained change under New Labour, that the evidence base for successful change is very limited and changes in service delivery are difficult to achieve. In fact, the evidence suggests that, as organisational cultures and institutional structures can be extremely robust, they may only respond well to specific, localised, and incremental change efforts (Harrison, Hunter, Marnoch, and Pollitt 1992b; Meyerson and Martin 1987; Peck and Crawford 2004; Pettigrew 1998; Pettigrew 1973).

The importance of strong, internally coherent, and organisationally specific approaches to change is discussed at length in the work of W Richard Scott (Scott 2001). Integrating many of the themes discussed above, he argues that organisations consist of three central 'pillars', "cognitive, normative, and regulative structures and activities that provide stability and meaning to social behaviour." These three pillars provide alternative bases for legitimacy which are transmitted by various carriers (ideas, values and rules). Each operates at multiple levels of jurisdiction; one pillar and its associated 'carrier' may be more dominant, but none is necessarily exclusive of the other. Virtually all organisations and institutions are made up of combinations of regulative, normative, and cognitive elements (Scott 1998). The repeated enactment of these elements, whether rules, values or conceptions, by people within institutions provides an internal sense of stability and common purpose and projects a veneer of objective reality externally. This suggests that in Trusts in which institutionalised processes are being transformed against prevailing NHS norms, there would need to be a very high degree of coherency in the alignment of the goals, structures, processes, accountability mechanisms, and reward systems, as well as congruency in the actions of both the management and the managed. Such congruency will have no value however in the absence of an ability to imagine an alternative way of being for the organisation, to inspire others to see it also, to believe in it, pursue identified achievable gaols and

means for achieving it (Morgan 1997), to receive feedback about progress, to learn continuously, and to effectively disseminate new knowledge (Senge 1992).

I therefore decided that I needed to understand both the history and development of the NHS as it related to the conduct, coordination and management of clinical work. I also decided that I needed to examine the histories of the two study Trusts for congruency and coherency in the alignment of structures, activities and values prior to examining more recent factors associated with the Clinical Management Development Project.

Conclusion

My final choices about relevant themes in the reorganisation and coordination of care in the study Trusts, the research design, the collation and reportage of my results, and the interpretation discussion of my findings reflect the priorities identified in the above discussion. Some secondary themes, such as the management and conduct of the CMD project itself and the way in which it 'played out' in the various health economies, have been included as background material and to provide important snippets of relevant information about local Trust strategies and conditions.

Chapter Three

Method

Introduction

As a result of my initial questions and my reading I decided to use interpretative structuralism to frame my approach. Hardy and Phillips (2002) ague that interpretative structuralism emphasises the importance of the social context of the phenomenon being examined, and seeks to explore and understand the way in which socially produced ideas and objects constitute a "reality" that is then maintained through repeated enactment. Once the generation of the status quo is understood, stakeholders with an interest in change, including researchers and policy advisers, can then begin to develop ideas for how change might be successfully introduced into that environment.

I chose a mixture of techniques to examine, in relative detail, the external and internal organisational contexts in the study Trusts in order to understand their relevance for the implementation (or not) of ICPs as a means for improving the coordination of clinical work. These were:

- An historical review of how NHS hospital care was traditionally organised, attempts to change this (especially around the management of work), and the outcomes of these
- A review of Trust documents
- A survey of Trust staffs' views about:
    - Professional cultures around aspects of healthcare work and its management
    - How their own clinical performance and experience of work could be enhanced
    - How services can be improved
- Interviews with senior staff about their views of the organisation, what constitutes good clinical management, whether/how this relates to organisational management.

The survey and interview schedules are attached in Appendices 1 & 2.

Historical Review

This involved a thematic review of historical policy documents and related academic comment about the history of the NHS, the management of hospitals, and their relationship to the management of clinical work. It drew upon a wide variety of sources and databases. The results of this review are reported in Chapters Four and Five.

Document Review

A review of documents internal to the Trusts since amalgamation was undertaken. Documents included were pictorial representation of Trust structures, vision statements, Board minutes, Executive committee minutes, minutes from committees reporting to the Executive committee e.g. clinical governance committee reports, financial reports, required internal policy documents for example policies relating to risk and safety, minutes of committees relating to the CMD project, publicity papers such as newsletters, internal communications such as the email spill down of Department of Health news, alerts and instructions to Trust executives, some pathway documents, Commission for Health Improvement (later the Healthcare Commission) reports, NHS staff survey results, and for North Tees and Hartlepool NHS Trust, the Darzi review's report. The Trusts' websites were also examined.

Where possible, documents relating to the predecessor Trusts were also included. These were limited, however, in coverage (essentially the only available documents were Trust Board minutes and some financial reports) and in time frame; in both study Trusts few documents from the predecessor Trusts had been kept.

Information from these documents was used to develop an understanding of the Trusts' histories, structures, internal emphases in focus and approach, the Trusts' self depiction to its community, and the extent to which language in use in the Trust reflected or implied a view of clinical work. This information is not specifically reported in any one chapter however it informs the descriptions and discussions in Chapters Five, Six and Seven.

Survey of Staffs' Reform Values

The survey results in this thesis are derived from a survey conducted as part of the Clinical Management Development project. The CMD project ran from 2002-2004 in four NHS (hospital) Trusts and their associated Primary Care Trusts (PCTs) in Northeast England and Yorkshire.

Study Sites

The selection of individual Trusts was not random but depended on the willingness of a hospital's senior clinical and managerial staff to participate. Accordingly, the survey results reported in this thesis have, in effect, been derived from a series of case studies. As such the results may not be representative of NHS Trusts more generally. Although the primary study sites, the NHS Trusts and their associated PCTs self-identified for participation, organisations associated with PCTs, such as general practices and district nursing units, were identified by the PCTs; PCT staff assisted with the recruitment of staff participation within these further organisations.

Sampling procedures

The ideal sampling frame within each health economy consisted of simple random samples of 30 staff within each occupational group: medical managers, medical clinicians (surgeons and physicians), general managers, nurse managers, nurse clinicians, allied health managers and allied health clinicians in hospital Trusts; Trust managers including PEC members, community nurse managers and clinicians, allied health managers and clinicians in PCTs; and general practitioners, practice nurses and practice managers within general practices. Assignment of respondents to occupational classes was determined by each of the Trusts and practices who also prepared the (occupation group based) staff lists from which the random staff samples were obtained. Medical managers were defined by their employers as including clinicians who spent 5% or more of their time performing what were regarded by senior management as managerial tasks.

Where a sample member failed to return a completed questionnaire they were followed up twice. In those cases where it proved impossible to contact a respondent, i.e. they

had either left the organisation or were on extended leave, a further member of each of the sub-populations was selected at random. Where the overall population of a particular occupational class within an organisation fell below its nominated sample size (a common event) all the members of that class were included in the sample. The numbers for some occupational groups are slightly larger than thirty. The reason for this is that in some organisations questionnaires were distributed to the whole staff population during local 'timeout sessions'. The sample was also somewhat constrained in that, within secondary care, at least thirty percent of the sample (where applicable) included staff who treated patients with a fractured neck of femur. This limitation was included to ensure that the views of staff whose work was anticipated to be a focus for the developmental phase of the Clinical Management Development project were represented in the survey.

The views of 987 staff across all project partners were obtained (refer Table 3.1 below). Provided no inferences are drawn from the data as to the incidence of a particular item in an organisational or occupational category (when the relationships between the sample sizes and sub-population sizes would have to be taken into account), the sample may most conveniently be treated as a simple random sample in time drawn from the four health economies. The various statistical tests and significance levels have been used primarily to describe the strength of a relationship or difference rather than as a basis of an inference to a larger population. Analysis showed that results for each organisational type were generally consistent across health economies. Small differences existed but these were relatively minor.

Table 3.1 Completed Questionnaires by Occupational Class and Organisational Type

	Medical Clinician	Medical Manager	General Manager	Nurse Managers	Nurse Clinician	Allied Health Manager	Allied Health Clinician	Total
SCTs	**103**	**24**	**63**	**69**	**81**	**51**	**63**	**454**
	Lead Clinician	PCT General Manager	PCT Nurse Manager	PCT Nurse Clinician	General Practitioner	Practice Nurse	Practice Manager	Total
PCTs	**32**	**87**	**39**	**111**	**138**	**65**	**61**	**533**

When analysed by health economy the actual survey population was constructed as summarised in Tables 3.2 and 3.3 below:

Table 3.2 Sample by Acute Care Trust

	Medical Clinician	Medical Manager	General Manager	Nurse Managers	Nurse Clinician	Allied Health Manager	Allied Health Clinician
Trust A	**21**	**5**	**22**	**14**	**10**	**17**	**18**
Trust B	**39**	**9**	**16**	**23**	**34**	**21**	**19**
Trust C	**19**	**5**	**11**	**16**	**19**	**4**	**10**
Trust D	**24**	**5**	**14**	**16**	**18**	**9**	**16**
Total	**103**	**24**	**63**	**69**	**81**	**51**	**63**

Table 3.3 PCT Sample by Health Economy

	Primary Care Trust				**General Practice**		
	Lead	GM	NM	NC	GP	PN	PM
Health Economy A	3	16	6	12	9	5	5
Health Economy B	8	30	5	38	33	16	24
Health Economy C	6	11	7	7	14	9	8
Health Economy D	10	22	17	29	50	27	18
Health Economy E*	5	8	4	25	32	8	6
Total	32	87	39	111	138	65	61

*Participation by this health economy was limited to one PCT participating in the phase one staff survey only

Questionnaire Design and Analysis

The questionnaire closely followed the format of a validated questionnaire used in previous research (Degeling et al. 1998; Degeling et al. 2000a; Degeling, Kennedy, and Hill 2001; Degeling et al. 2002) which in itself was partly comprised of other validated instruments. (It has been used previously to make cross-national comparisons of the views and values of health care workers in western economies.) For this study, the entire questionnaire was piloted using different groups within hospitals in the UK. Minor adjustments were made to adapt the instrument to English circumstances.

Closed ended questions

The questionnaire firstly elicited demographic data on respondents' occupation, qualifications, sex, age, clinical and managerial experience, and employment duration with their hospital. Individual items within the questionnaire were worded to fit the

occupation and organisational circumstances of respondents. Thus, nurses were asked to describe their highest educational qualification in nursing while lay managers were asked to supply their highest educational qualification in management. General practice staff were asked how they perceived the goals of the Practice whilst hospital staff were asked how they saw the goals of the hospital.

It then used sets of interrelated close-ended questions to ascertain respondents':

- Views on some issues that have been said to face the health care system,
- Assessments of a number of strategies for addressing resource issues confronting the health care system,
- Perceptions of what they regarded as important for their professional autonomy,
- Perceptions of how certain expectations affected their professional autonomy,
- Views about the relative importance of factors which may produce variations in clinical practice,
- Views on a range of factors which can affect their clinical practice,
- Views on a range of issues pertaining to resource allocation in clinical settings,
- Perceptions of the scope and limits of their accountability,
- Views on who should be involved in formulating clinical care standards,
- Views about which knowledge bases should be included in setting medical/nursing clinical standards,
- Assessments of nominated strategies for improving a clinical unit's overall performance.

On all substantive questions, across all occupations and organisations, the form of the questions was essentially identical however two sets of substantive questions were omitted from lay managers' questionnaire forms as these were only relevant for people with clinical experience.

Within these close-ended question banks items were arranged using one of three question formats. With the first, respondents were required to rank a set of items

(statements) in terms of their perceived importance. With the second, respondents were asked to allocate percentage points between a set of statements to indicate their subjective assessments of the prevalence of nominated situations or conditions. In the third (and the most often used form), respondents were asked to rate individual statements (using a five-point Likert scale) to indicate their degree of agreement or disagreement with the statement *or* to describe their assessments of its appropriateness or inappropriateness.

The collected data from Likert scale questions were difficult to assess in relation to single items. Rather these were explored in relation to other related items i.e. the responses to a number of linked items were analysed for an underlying structure in participants' responses. For example one of the questions asked respondents to assess the extent to which variations in medical practice "are caused by shortcomings in medical/surgical education". The assessments of individual respondents could have arisen from a) having studied a report which sought to establish an association between clinical practice and medical education; b) direct experience of working with colleagues from different medical backgrounds; c) a personal recognition of areas where there was a knowledge gap. The point here is not that respondents might or might not have provided answers on these bases but that it was apparent there was an underlying pattern in responses to items relating to clinical practice variation.

The relationships between items and across banks of items were therefore explored initially using chi squared test. (Monte Carlo methods were used when the expected values were less than 5). The results (not reported here) suggested that the relationships between the items may be regarded as essentially linear in form. These tests were carried out using either one way analysis of variance or two way analysis of variance modified to cope with the unequal number of cases in each cell. The results indicated that the bulk of the survey items discriminated strongly between occupational categories. Principal component analysis was then used to derive a set of orthogonal factors, which typically accounted for 50–60% of the variation in the responses to items within a theme. Respondents' scores on a factor were regarded as reflecting patterns of values, meaning and beliefs that structured their assessments of the issues and/or

matters that were referenced by themed items that loaded on the factor in question. Respondents' factor scores were explored, using analysis of variance, to establish the extent to which the already noted occupation-based differences were preserved and to test whether the results varied when other demographic variables such as gender, age and education were taken into account. The results showed that the effects of these secondary demographic variables were minor relative to the impact of respondents' occupation.

Factors across organisations were examined for their stability. The result showed that factors were relatively stable. In light of this, the responses of all cases from each organisation were combined and again analysed (using principal component analysis) to derive a set of common factors on which all respondents could be measured and hence compared. Finally, discriminate analysis was used to examine the patterns of difference between the mean scores for all the hospital reform related factors by occupation. The results suggested that the responses varied primarily along two dimensions.

Issues with the quantitative data

Whilst surveys have traditionally been regarded as a quantitative research method, the surveys here are surveys of opinions. As such, the participants' responses, whether to Likert scales or opened questions, are interpretations of complex social concepts and phenomena at a particular point in time and in a particular social context. In that sense, the data are not strictly reproducible in the positivist sense and could be classified as essentially qualitative data. They provide an insight into the context and values of staff around the conduct of clinical work and its organisation, indicating both commonalities and differences between staff within and between the two study Trusts. The findings from this section of the survey are reported in Chapter Eight.

Opened questions

Open-ended questions (to permit free response) sought to elicit respondents' views on their:

- Perceptions of the role of various parts of the health economy,

- What could be done to improve the operation of the health economy and its constituent components, and
- What could be done to improve their working lives.

The responses to these questions were typed into an Excel spreadsheet and grouped by Trust and occupation. A content analysis was undertaken to identify the major themes that emerged within Trusts and within occupational groups. A coding frame was developed out of the responses to categorise these. A thematic analysis of the findings from the open-ended questions is reported in Chapter Nine.

Interviews

All members of the executive management teams, all the divisional (medical) directors in each Trust, the lead staff member for clinical pathways during the CMD project, and the Trust-project liaison person were invited to participate in the interviews. (In CHFT the project liaison officer was the Organisational Development Director, a member of the Trust executive. In NTH project liaison officer was the Assistant Human Resource Manager for Organisational Development who was not a member of the executive team.) The majority of the executive team in both Trusts agreed to be interviewed. The exceptions were the Director for Human Resources in both Trusts and the Medical Director in NTH. The staff member who had been medical director during the Clinical Management Development project, however, did agree to participate. The position of Finance Director in NTH was vacant hence this position on the NTH executive team is not represented in the interviews. No divisional medical director in either of the Trusts agreed to participate; the only exception was the acting divisional director for Medicine and the Elderly in Calderdale and Huddersfield NHS Trust. As I did not consider that one interview would be representative of medical directors' opinions and may in fact skew the findings, I did not include this interview. The ICP leads in both Trusts also agreed to be interviewed.

The interview schedule was highly structured; however, I have styled the interviews as semi-structured. The reason for this is that I had (and still have) an extended working relationship with many of the interviewees. I had deliberately cultivated an interactive working style when undertaking developmental activities in these Trusts to promote

trust and reciprocity. I anticipated, and subsequently verified, that it would be very difficult to step outside that working relationship when interviewing. As expected, the interviewees often conducted themselves within that framework and, in order to maintain the working relationship, so did I. Furthermore the interviews often referred to matters about which I had prior knowledge and experience. In this sense the interviews at times departed from the standard, relatively objective and uninvolved interview format, taking on aspects more akin to that of a participant observer. The interviews were content analysed; a thematic summary of the findings is reported in Chapter Ten.

Chapter Four

An Historical Perspective on the NHS with a Special Focus on the Management of Clinical Work

Introduction

NHS history is characterised by reform efforts that have sought to reshape professional priorities and organisational structures in order to improve and ensure delivery of effective and efficient care. The issues faced in the early days of the NHS - how best to organise and manage the service; fund it; balance the frequently conflicting demands and expectations of patients, professionals and the public; and how to target resources to areas of greatest need - remain fundamental issues that successive governments have to address. The pressure for simultaneous resolution of these issues to ensure the key tenets of the NHS – a national service, free at the point of entry for all who have need of it has grown over the past 30-40 years with changing economic and societal issues.

The difficulties in simultaneous resolution of many of these issues were inherent in the way the NHS was designed (Barnard 1976; Pollitt, Harrison, Hunter, and Marnoch 1988; Strong and Robinson 1990). The nearly sixty years of NHS history have therefore been a history of numerous initiatives in pursuit of efficiency, effectiveness and respectful patient 'experience' in healthcare delivery. This chapter describes the traditional structures and management practices of NHS hospitals, highlights important reforms and initiatives, and provides a rationale and critique of each.

The Design of the NHS

The NHS was established to meet several complementary concerns. It was in part a response to widespread expectations that government should ameliorate the deprivations of the Second World War and the associated shortages including, in the new centres of population, healthcare services. It was in part an attempt to promote social equity, economic reconstruction and domestic growth. And it was in part a compromise response to the inequities, tensions and vested interest within the prior existing structure of healthcare provision in the UK (Barnard 1976; de Jong, Groenewegen, and Westert 2003; Department of Health 2004; HMSO 1942; Levitt 1979; Milburn 2001; Pollitt, Harrison, Hunter, and Marnoch 1988).

It was primarily centrally funded with a tripartite structure: general practice, provided by independent contractors on a capitation basis and administered by an Executive Council (dentists, pharmacists and optical practitioners were also retained on this basis); community health and preventive services such as maternal and child welfare, health visiting, ambulance services and the School Medical Service, provided by local government; and hospital services. Teaching hospitals were overseen by Boards of Governors who reported directly to the Minister of Health; others were overseen by Hospital Management Committees which oversaw groups of hospitals within the region. Each Board and Committee reported to the Minster of Health and each employed an administrator to oversee its responsibility for service provision.

Traditional Structure and Management Practice in Hospitals

Historically the hospitals in the NHS, as elsewhere, were organised internally around the specialist functions of running a business, namely accounts, finance, R&D, personnel and so on. In addition hospitals organised their operational processes on a functional basis according to established healthcare disciplines and roles; medicine and nursing and, in later years, allied health. As expert opinion was that no clear boundary could be drawn between medical, lay and nursing administration, management of hospitals was consciously shared between them. Individual hospitals were usually managed by a triumvirate of the Hospital Secretary, the Matron and the Medical superintendent or other medically qualified administrator. A "conception of partnership between these three .... should be regarded as fundamental and should determine the lines of all future development" (Council 1954) p20).

Functional arrangements such as these were believed to apportion roles and responsibilities in a rational and efficient fashion, permitting the development and maintenance of specialist knowledge and skills, efficient resource allocation and effective centralised and prescribed control over all organisational operations. In this way they were considered to express the principles and values of the scientific management paradigm (Fayol 1949; Stoner 1982; Taylor 1911; Urwick 1938).

Contrary to the deskilled work places of 20th century industry (Braverman 1998), however, the expertise and knowledge of hospitals' 'core business' and its associated production processes did not (and still do not) reside with either the administrator or the managing triumvirate. The 'productive expertise' was under the care of the highly skilled, autonomously functioning professionals, principally doctors. Hence, unlike other functionally organised businesses, hospital managers were not in control of the production process. It was not expected that they should be; moreover professionals, more accountable to their professional bodies than to organisational management, did not contemplate, much less accept, even the idea of management's right to control (Bettner and Collins 1987; Edwards and Marshall 2003; Harrison and Lim 2003; Marnoch 1996).

Despite their centrality to the operational processes of the hospital, health professionals also did not have overall or collectivised control of the production process, at least in any collective or organisationally purposive sense. Clinicians did not establish, direct or control the processes of treating patients by rational and prescribed management methods. The patterns of clinical activity that occurred in hospitals and across health economies, and the processes ensuring the appropriate resource and clinical requisites for those treatments, resulted from continual renegotiations of patterns of clinical and financial relationships (Strauss et al. 1963). The actual provision of care was an opaque process, fragmented along and within professional lines; control over it was diffused amongst many professionals (Elwyn and (eds) 1999; Lowe 1998) and rarely understood in its entirety by any one person. The broadest level of fragmentation of care occurred along familiar professional lines, doctors were responsible for 'cure' activities, nurses for 'care' activities and allied health professionals for therapeutic activities (Mowry and Korpman 1987; Wicks 1999; Witz 1992; Wolf 1989).

Medicine was (and remains) divided into many specialities and sub-specialities each highly particularistic (and often exclusionary) in its disease or anatomical focus and its standard approaches to appropriate care e.g. cardiac surgeons intervened surgically whilst cardiac physicians intervened using drugs and other 'non-invasive' procedures

(Veith and Marin 1996). Further, medicine was and is traditionally arranged on a very individualistic basis. Hospital employed doctors were in control only of their particular aspects of the treatment for specified conditions of specified individual patients. Although in treating patients for a particular condition they were also responsible for the care conducted by others at their behest (e.g. nurses and therapists), they were not accountable for the totality of care for that patient. Different doctors were responsible for treating different conditions in the same patient (hence for complex patients there can be blurring of roles and accountability even within medicine). Each doctor was responsible only for the patient immediately in his/her care; he/she was not responsible in any way for the population of patients with the same condition in the hospital.

Each doctor's accountability for his/her individual patient was also highly individualised. In post war Britain all consultants were equal, no doctor had responsibility for or to another (Bujak 1998; Strong and Robinson 1990) even for the training of, and delegation of responsibility to, more junior doctors. This was and remains a relatively fluid process influenced by the competency of the junior doctor in the eyes of his mentor rather than according to defined rules or strict lines of accountability (Davies and Francis 1976). The result was that "no hospital had a boss, no doctor had a manager" (Strong and Robinson 1990) p15). In contrast, other health professionals, such as allied health professionals and in particular nurses, were usually multiply accountable – to the doctor under whose authority there were working, to their direct manager and to their professional body.

In this organisational and political environment, hospital structures and operations more closely resembled the interaction of co-located 'tribes' (see figure overpage). The tribes had (and have) varying histories, internal organisation, cultures and power; fierce internal loyalties; different perceptions of the nature of clinical work; and, despite their common commitment to patients' welfare, lacked a sense of wider vision (Strong and Robinson 1990).

In such an environment the hospital manager/administrator's role was more akin to a diplomatic organisational maintenance one, not one of responsibility for ordering the

strategic and operational direction of the organisation a` la scientific management. Their role was essentially reactive and consisted of mediating the competing claims of the various professional groups and providing the resources and facilities that the individual professional groups said that they needed (Degeling 1993a; Harrison 1988; McMahon and Newbold 1986) in ways that maintained relationships between the professions. The resulting lack of a strong coordinating managerial process throughout all levels of the organisation resulted in an administrative process focused on 'issues management', strengthened the individual professions' ties and interests, left medicine's preferred work practices unchallenged by staff of other professions, created a multiple hierarchy within the organisation, and significantly impeded any ability to provide a consumer oriented and effectively coordinated service (Davies 1980; Davies and Francis 1976; Strong and Robinson 1990; Tap and Schut 1987; Zadoroznjy 1998).

These deficiencies were noted early on. In 1966 the Advisory Committee for Management Efficiency in the National Health Service (Advisory Committee for Management Efficiency in the National Health Service 1966) criticised the lack of supportive and critical elements of industrial managers' roles in British hospital management (quoted in (Harrison 1988) p13) and in 1967 the Advisory Committee on Hospital Management (Joint Working Party 1967b) advocated the setting in place of arrangements so that "*someone* had ... command of the (hospital) with authority over the rest of the staff" (emphasis added). Nevertheless, and despite the "obsession with notions of better management" (Harrison 1988), subsequent attempts to strengthen management of hospitals did so from within the context of the individual professions, maintaining the triumvirate arrangement. For example, the 'Cogwheel' reports on the organisation of medicine recommended the establishment of speciality based divisions within hospitals, each of which would send a representative to a Medical Executive Committee whose chairman would act as the chief medical spokesman for the hospital (Joint Working Party 1967a); the Salmon report recommended a hierarchical structure within nursing (Ministry of Health and Scottish Home and Health Departments 1966), and the Zuckerman Report and Noel Hall Report recommended separate management structures for scientists and technicians and pharmacists respectively (Watkin 1975).

Consensus decision making

The insufficiency of these arrangements for providing effective management increasingly stringent budgetary circumstances however became increasingly apparent during the 1970s (Klein 1983). Increasing consumer service demands, coupled with the simultaneous rapid expansion of costly care technologies, exerted significant cost pressures that were difficult to contain. Effective management of the NHS increasingly became a major preoccupation. The financial pressures challenged the way that both policy agents and hospital managers conceived of the efficiency, effectiveness, performance, design, roles and responsibilities of hospitals and their operation (Harris 1977; Klein 1985; Schieber and Poullier 1990; Tap and Schut 1987). In particular, they highlighted the fact that medical clinicians were responsible for the bulk of hospital-based healthcare expenditure without any formal accountability or responsibility for that expenditure. From as early as 1972 there were calls for more clinician inclusive management approaches such as management teams of "those whose unanimous agreement is essential to the making and effective implementation of decisions for the totality of care" (DHSS 1972a)p15).

A series of reforms were undertaken during this period, the most significant of which were those of 1974 and 1983. The 1974 reorganisation gave the NHS a new corporate structure and management ethos. New 'local' layers of management (areas and districts) were added and a host of innovations' based upon 'modern business methods' were introduced (Strong and Robinson 1990). These included strengthened nursing hierarchy, managerial hierarchies in a number of health professions not previously so organised including dentistry and various therapy professions, an elaborate planning system, management training for health professions, and local community representation (Levitt 1979). However funding was still centralised and the reorganisation was not so business-like as to introduce a CEO or anything approaching a recognizable chain of command.

Rather, following prevailing intellectual opinion that doctors should not be accountable to non-clinicians (Harrison 1988), the 1974 reform initiatives, reinforced the multiple hierarchies of hospital management by introducing the notion of 'consensus decision-

making' within hospitals, district, area and regional health authorities (DHSS 1972a). These bodies were headed by multiprofessional teams consisting of the administrator, treasurer, a nurse, and two doctors, a consultant and a GP, representing clinical (and not managerial medical) interests. Team members had personal responsibility for their own spheres of work; however, strategic and multidisciplinary issues were to be decided collectively. Elaborate consultative structures within the professions, focused upon elected professional advisory committees, were set up to aid the teams' coordinating work with professions. Authority relationships between teams existed only between the various area and regional health authorities. In deference to the notion of consensus other team relationships were restricted to monitoring: the higher level teams could advise but not instruct lower level teams. In effect the core principles of medical self organisation were applied to the whole service; it was to be a self organising service coordinated through consensus decision-making (DHSS 1972b) (Levitt 1979; Strong and Robinson 1990).

In retrospect the apparent rationale for consensus decision making was two pronged (Harrison 1982). On one part it was assumed that the NHS was a unitary organisation, that team members' perspectives were fundamentally aligned and their objectives similar, and that participation in teams would produce greater commitment to jointly solving the NHS' management problems. This, together with the widening of the range of specialist knowledges within the team, was expected to produce more innovative and effective solutions and greater ownership of the decisions which, in turn, would facilitate change (Gourlay 1974). From an alternative perspective, consensus decision-making was a pragmatic management, a formal recognition that no practicable alternative to team management existed in a bureaucratically structured service so profoundly shaped by technical uncertainty, clinical judgement, the powerful sense of responsibility to individual patients by individual professionals and the dominance of what was effectively a medical syndicate (Jacques 1978; Strong and Robinson 1990). These arrangements did not, however, achieve the improvements being sought. The lack of a direct chain of responsibility throughout the NHS and within hospitals, the complexity of new management tiers, and the lack of management skills within the new hierarchies, meant trivial and routine decisions were frequently referred upwards

through the multiple organisations, often being unresolved until at least the District Management Team level (Harrison 1982; Haywood 1977). Some believed that the ability to refer decisions upwards suited those who used it as means to either distance themselves from unpopular decisions or to garner wider support for them (Royal Commission on the National Health Service 1979). This argument, however, was dismissed by Harrison as being both contrary to the evidence and (at the level of chief officers) sound management practice (Harrison 1982).

All of these issues led to significant disillusionment and dissatisfaction within the Service. More significantly from the perspective of this thesis, these arrangements failed to provide mechanisms for integrating and managing the various professions and their work at levels closer to the conduct of that work. Whilst at the macro level there were some real successes in planning and containing costs, at the clinical level the negative features of tribalism were readily apparent; there was little coordination within hospitals and work places, very little knowledge about individual medical activity and, in contrast to emerging trends in the US health industry, no techniques for the micromanagement of health provision (Ham 1985; Pollitt 1990; Strong and Robinson 1990) .

Consensus management however remained in place until the early 1980s. Attempts to financially manage the Service prior to this time were restricted to the (bitterly contested) removal of private beds from the NHS in 1974-76 (Klein 1983; Klein 1980), the introduction of budget caps in 1976 (Klein 1983), and a system for centralised management cost control in 1978 (Levitt and Wall 1984) . Even the incoming Thatcher government, with its desire to reform the NHS structure and its commitment to more market based provision of services and closer supervision of public instrumentalities, initially explicitly rejected the introduction of command management through the creation of chief executive posts (DHSS and Welsh Office 1979),p7).

The Rise of General Management

Nevertheless it was evident to all that major change was required. The Conservative government's reform of NHS management began slowly with structural changes such

as the abolition of the area tier, the creation of 'units' within districts commonly centred around focused clinical activities such as psychiatric hospitals or community health services in 1981, and the establishment of management teams within each level of the service in 1982. However what some regarded as a tidal wave of change aimed at radically shifting the culture of the NHS began in 1982 (Harrison 1988). Included in the process changes were the introduction of hierarchical annual performance reviews, cost-effectiveness scrutinies of services such as transport and residential accommodation, 'efficiency savings', central control of manpower numbers, restrictions on doctors' prescribing rights, a review of NHS audit arrangements and the publication of the first set of performance indicators. This time period also saw the commencement of more market-based operational approaches with the initiation of compulsory competitive tendering for catering, domestic and laundry services (Bristol Royal Infirmary Inquiry 2001a; Pollitt, Hunter, Harrison, and Marnoch 1991).

Virtually all these initiatives were poorly supported within the Service. Performance indicators in particular were criticised for the unreliability of the associated data and their lack of clinical relevance, especially in relation to the quality and outcomes of care (Bristol Royal Infirmary Inquiry 2001a). These criticisms were to become a familiar refrain to subsequent initiatives that sought more detailed management information on professional activity.

The 1983 'Griffiths' report supported and amplified the tenor of the management changes, marking a major change in thinking about the management of the NHS. It departed from orthodox thinking about the nature of healthcare and its delivery, depicting healthcare as being just another product, requiring coordination and management just like any other business. Hence, although the report did not challenge the functional structure of hospitals and wider organisations, it strongly endorsed elevating the role of general management, replacing consensus management with a more linear approach. A single chain of command from a general manager to the clinical frontline was to be established to provide overall direction and control ... "If Florence Nightingale were carrying her lamp through the NHS today, she would almost

certainly be searching for the people in charge" (Department of Health and Social Security 1983), p12).

The Griffiths report acknowledged the power and dominance of the medical profession, emphasising the role of doctors as natural managers in healthcare and their moral and organisational responsibility for the financial aspects of their clinical work. It recommended that efforts be made to provide appropriate administrative, information and management budgetary systems in support of this role (Department of Health and Social Security 1983). Further, the report recommended drawing into the NHS a new cadre of managers with commercial expertise comprised of people with expertise in other industries and NHS staff with untapped leadership potential, particularly doctors, who aspired to general management positions. (Officially at least) healthcare management as the coalition of separate but equal professions was dead.

These changes in thinking required hospital managers to move from administration as the governing principle to operational and strategic management as their governing principle and with that, a stronger focus on the products of the hospital and their means of production (Braithwaite 1999; Grant 1986). Subsequent years saw an array of managerial tools and techniques into the NHS such as (Pollitt 1996). However these initiatives occurred at an organisational level that was relatively abstracted from the clinical workplace such as the heads of clinical units, divisions or upper management and did not affect individual clinicians directly (Foster 1986; Pollitt, Harrison, Hunter, and Marnoch 1988) and remained focused upon the management of traditional functions and issues such as finance, personnel management etc. Though their use became routine at these upper management levels their introduction and operation at more professionally immediate levels were often strongly contested by clinicians opposed to the introduction of any practice likely produce greater transparency into medical workloads and clinical decisions (Ham and Hunter 1988; Pollitt 1996).

Nearly a decade after the general management revolution the impact of what came to be known collectively as the 'Griffiths' changes was very unevenly distributed. Though the broader structural changes were substantive and greater clarity was achieved in

the role, responsibility and authority of senior managers these did not permeate the hierarchy ... "below UGM level, things became murky" (Harrison, Hunter, Marnoch, and Pollitt 1989); p9). Small changes were noticeable in some areas such as routine operational decision-making by nurses but in other arenas change was negligible. At more strategic levels senior managers' agendas were not as wider ranging as was initially anticipated. The central government's almost exclusive focus upon fiscal concerns meant senior managerial efforts remained overwhelmingly on the management of inputs, particularly the need to run a balanced budget (Harrison, Hunter, Marnoch, and Pollitt 1989).

This dominance of financial concerns contributed significantly to the persistence of the dual hierarchy in hospitals for a variety of reasons. On the professional front consultants retained far more power over issues related to the obtaining of substantive improvements in the management and delivery of care, including the movement of resources out of acute care and into the community, than Griffiths had supposed. Further many doctors were just not interested in management, and additionally, managers who were concerned with patient issues often found themselves sympathising with clinicians' concerns. On the managerial front and in contrast to doctors, managers were employed on fixed short term contracts. Their job security depended upon their bottom lines, not the outcomes of the other agendas. The new hierarchical nature of decision making meant that many middle managers found their efforts to attain the desired bottom lines (by building credible authority and trust with doctors) were often undermined by more senior managers, acting on the basis of decisions taken further up the line at regional or district level. Their credibility and efforts to influence clinical decisions were further derailed by inadequate or inaccurate performance data.

By the beginning of the purchaser – provider split (or 'internal market') the 'revolution' in NHS management had altered the larger geographical structures of the NHS and increased the authority of senior management at least within these hierarchical structures. Within hospitals in many instances nurses and other health professional had accepted the notion of general management and numerous initiatives (discussed

below) had been introduced to deal with the various issues facing the NHS. But, at the level at which the clinical work was done, traditional clinical and managerial practices and relationships continued essentially unchanged.

Resource management

The Resource Management Initiative (RMI) of 1986 was aimed at creating incentives for doctors to accept devolved budgets for the direct and indirect costs of patient care, to accept management positions, and to undertake service planning (Dearden 1990; Sturt undated). This marriage of the financial and clinical agendas was supported by the medical hierarchy in a joint statement by the Department of Health and the Joint Consultants Committee (DHSS 1986) attached to White Paper, 'Working for Patients' (Department of Health 1989), which incorporated the fundamental tenets and timetable of the RMI. The RMI coincided with the work of the NHS/DHSS Steering Group on Health Services Information which recommended simplification, standardisation and hence comparability of minimum data sets (the Korner reports) and hence improved control and performance information for use by all operational levels of all disciplines in hospitals (DHSS 1984a; DHSS 1984b; NHS/DHSS Steering Group on Health Services Information 1984; Perrin 1988). Together these represented the first concerted attempt within the NHS to routinely collect accurate casemix data about individual patients in order to aggregate information about activity, resources and required care (Keen, Buxton, and Packwood 1993).

The RMI, and its associated agendas, were not entirely new. By the early 1970s treasurers of healthcare organisations had systems sufficient for calculating average costs per inpatient or outpatient or by given functional department and a few small scale pilot projects involving clinicians in budgeting for direct costs of patient care had been trialled (Bourn and Ezzamel 1986; Pollitt, Harrison, Hunter, and Marnoch 1988) (Wickings 1978). Further, the 1978 Royal Commission's recommendations (Royal Commission on the NHS 1979) on testing the redeployment of resources through clinician involvement in speciality budgeting had been enacted on a trial basis in three health authorities in the early 80s (Perrin 1988). Post Griffiths, efforts on resource management, the management budgeting initiatives (MBI) (DHSS 1985), were

especially prominent in the acute sector (Disken, Dixon, Halpern, and Shocket 1990; Packwood, Keen, and Buxton 1991; Strong and Robinson 1990).

However the general consensus amongst commentators is that these prior attempts to incorporate clinicians into financial management were failures. The principles, incentives, and outcomes of these initiatives were heavily dependent on a number of prerequisites most of which were deeply problematic: willingness among clinicians to co-operate in the development of the budgetary systems, appropriate computerised data collection systems, an acceptance by professionals that output could be managed, defined reporting lines and a systematic capacity for dialogue between managers and clinicians on the patient care to be provided. Perhaps the most fundamental and problematic prerequisites were cultural changes such that general managers were willing to 'hire and fire' and clinicians were willing to change their 'habits of a lifetime' in terms of their clinical practice patterns in treatment, training medical teams etc (Perrin 1987; Perrin 1988; Pollitt, Harrison, Hunter, and Marnoch 1988; Sturt undated). In fact, clinicians were so disillusioned and anatagonised by the lack of consultation, inadequate planning and unreliable data generated in the MBI immediately prior to the RMI that the DHSS took the unusual step of noting that suspending MBI for the immediate future would be a sensible course of action "...where fundamental difficulties have been encountered or medical and nursing staff seriously antagonised..." (DHSS 1986) para 4 quoted in (Pollitt, Harrison, Hunter, and Marnoch 1988)).

In contrast, RMI was judged broadly successful (Foster 1986) (Keen, Buxton, and Packwood 1991) although in practice it was heavily weighted towards cost containment and complicated by the fact that "there was general confusion ...about how the RM process, objectives setting and improvements in patient care could be linked", thus providing few incentives for enabling service improvement (Keen, Buxton, and Packwood 1993). There were some successes in integrating doctors into management, increasing the general accuracy of inpatient data, and promoting the use of medical audit and the value of a variety and financial data in the eyes of consultants. Across the six pilot sites individual service providers agreed to the setting of written standards and

to the measurement of outcomes for selected procedures and treatments. One pilot site, Hudddersfield Royal Infirmary (a predecessor organisation to the Calderdale and Huddersfield NHS Trust), enjoyed several years of real success in integrating the financial and clinical aspects of care, with great enthusiasm amongst staff of all backgrounds (Freer 2005a).

On the other hand, across the pilot sites, implementation of information systems was generally slow, out-patients and referral data remained poor, and the clinical data generated was often profession specific, fragmented and poor quality. They therefore provided little useful information for either clinical or managerial purposes. Moreover nurses were marginalised in these initiatives and there was little evidence that the benefits from the initiative outweighed the costs or that the management changes had led to improvements in patient care (Keen, Buxton, and Packwood 1991; Keen, Buxton, and Packwood 1993).

Pollitt, Harrison et al, in a large scale study of the attitudes of staff to RMI, found very few enthusiastic managers and clinicians, many cautious managers and many determinedly sceptical doctors who were often not "diehards, resistant to any consideration of resource constraints.....many were perfectly prepared to acknowledge the need for efficiency and economy, and a number of them made critical references to colleagues who, in their view, disregarded such criteria" (Harrison, Hunter, Marnoch, and Pollitt 1989; Pollitt, Harrison, Hunter, and Marnoch 1988). In the view of many interviewees, RMI foundered because 'it was put to doctors in the wrong way'. At one site in which RMI foundered, the cause was not attitudinal but technological. It foundered because, in a period of financial restraint, there was insufficient investment in extending the capacity of the IT systems to meet the burgeoning (clinical and cost) informational inquiries generated by enthusiastic clinicians. The result was a cycle of profound disappointment and disillusionment leading to decreased commitment and poorer results creating more disillusionment ... "We demoralised the clinicians by enthusing them – and then disappointing them .... When I think of many good doctors heavily involved in RMI who lost all that passion, many now are just jobbers" (Freer 2005a). In other sites, RMI's potential to identify the costs directly controlled by each

consultant was not realised. The data that was generated was mainly high level aggregate data such as the numbers of patients treated, waiting lists and waiting times. This was attributed to a "deeply rooted reserve" by government to address the "highly sensitive issue" of clinical performance which traditionally had been "the exclusive domain of the professions" (Bristol Royal Infirmary Inquiry 2001b).

A series of financial crises faced by a number of NHS hospitals during the winter of 1987/8 led to the hasty incorporation of the RMI into the "internal market" espoused in the White Paper (Cm 555, 1989) despite the difficulties in obtaining and maintaining clinician support.

Medical Audit

As noted above, the same Health Notice that established RMI also detailed plans for a comprehensive medical audit (DHSS 1989) since RM could only be effective when based upon sound understanding and management of clinical processes. (Or because, viewed from an alternative perspective, structured audit is one of the few mechanisms equally applicable to clinical decision making and organisational efficiency.) It is not surprising therefore that medical audit suffered from similar problems as the RMI: poor (even overtly hostile) clinician perceptions of the initiatives, a lack of systems understanding about how to structure initiatives, management systems that were coordinated at the top but not at the level at which the clinical work was done, efforts contained within professional silos, inadequate information technology and, consequently, poor quality data (Johnston, Crombie, Alder, Davies, and Millard 2000; Miles, Bentley, Polychronis, and al 1996; Nolan and Scott 1994).

Medical audit (nursing audit and clinical audit were introduced in 1990 and 1993 respectively) was about "reviewing the delivery of care to identify deficiencies so that they may be remedied" or, in more detail, "the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient" (DHSS 1989). The central idea of audit, that health professionals take time to review, reflect upon, and reform their work as necessary, has always been part of the professional ethic

(Hopkins 1996). It was a voluntary exercise for professionals and their participation in it depended upon their commitment, enthusiasm and available time (Bristol Royal Infirmary Inquiry 2001b). There were no organisational structures, funding, time allocation or requirements for undertaking audit. The introduction of the official audit initiatives did little to change these arrangements or to introduce recognised authoritative standards for the performance or clinical work beyond those of the individual professions for which each clinical staff member had trained. Nurses simply sought to meet the standards of professional practice generally expected of them; doctors did likewise within their profession. And, as there were no standards, there were no benchmarks against which to assess the quality of the care given.

From the start clinicians had strong reservations about official audit believing, to some extent rightly, it was yet another attempt to bring them under management control. Respected policy advisors therefore recommended against making medical audit compulsory, arguing successfully that, although healthcare organisations should provide funds and other support for audit, it should remain a voluntary activity encouraged through appeals to professionalism (Ham and Hunter 1988). The consequence was that neither the processes, application, undertaking, and results of audit were systematic, strategic or nationally comparable. This led the DoH's Clinical Outcomes Group in 1993 to successfully advocate modification of the existing medical audit scheme. Multidisciplinary clinical audit was introduced and, with it, the beginnings of a systematic approach to audit, including various audit methodologies and publication of a clinical audit handbook. Continuing concerns about "considerable professional sensitivity" however led to clinical audit being presented as an educational tool rather than an accountability mechanism (Bristol Royal Infirmary Inquiry 2001a).

Clinician distrust of systematic audit was strongly related to their concept of profession. This includes the belief that professionals managed their own business hence managerially mandated audit, by diminishing clinical ownership of the audit process, diminished professionalism, restricted clinical freedom and autonomy, invited litigation, permitted hierarchical and territorial incursions into their domain, increased workloads and replaced valuable clinical time with time wasting and ineffective activities whilst

contributing little to improved care (Kerrison, Packwood, and Buxton 1993; McKenna 1995; Sellu 1996; Smith, Russell, Frew, and al 1992; Webb and Harvey 1992). Clinicians also saw it as personally threatening, blame apportioning, "professional witch hunting", and a means to reorganise their services thus threatening their employment (Black and Thompson 1993; Firth-Cozens and Storer 1992). Junior doctors additionally viewed clinical audit as an activity from which they received little support, direction and feedback, and which laid an unfair burden on them (Gabbay and Layton 1992; Gabbay, McNicol, and Spiby 1990; Lough, McKay, and Murray 1995). These concerns were also shared by junior therapists (Millard 1996; Robinson 1996a; Robinson 1996b).

Organisational shortcomings impeding effective audit and resource management were manifested in poor planning and systems. a multiplicity of audit methodologies with different techniques, requirements, measurements and action points often being used at the same time in the same healthcare organisation (for example mortality and morbidity reviews, small area analysis, preadmission certification, uni- and multi-disciplinary audits, audits conducted by audit staff and those conducted by clinicians) the results of which were not integrated into wider organisational processes (Buttery, Walshe, Rumsey, and et al 1995; Firth-Cozens and Storer 1992; Foster, Willmot, and Coles 1996; Walshe 1995; Willmott, Foster, Walshe, and al 1995). These organisational shortcomings were simultaneously the cause and result of other problems such as inadequate practical and financial resources (Chambers, Bowyer, and Campbell 1995), lack of time and support staff (Davison and Smith 1993; Karran, Ranaboldo, and Karran 1993), poor quality information systems, and intra-organisational confusion, even conflict (Buttery, Walshe, Rumsey, and et al 1995; Robinson 1996a). Time and time again researchers identified the absence of strong and supportive relationships between managers and clinicians and a lack of common perspectives on audit as crucial issues hindering the audits' effectiveness (Foster, Willmot, and Coles 1996; Robinson 1996b; Smith, Russell, Frew, and al 1992; Thomson, Elcoat, and Pugh 1996) (Lord and Littlejohns 1994; Webb and Harvey 1994).

These problems, together with the finding that there was little objective evidence supporting audit's value and that the depth of involvement across healthcare was still highly dependent on individual professionals' enthusiasm (Bristol Royal Infirmary Inquiry 2001a; Buxton 1994; Johnston et al. 2000), contributed to reviewers continuing to report in 2000 that audit was still essentially confined to 'enthusiasts' (Johnston et al. 2000).

Quality assurance and quality improvement

The resource management and clinical audit agendas were not the only agendas aimed at improving NHS efficiency and effectiveness over this time frame. A myriad of quality initiatives based on ideas drawn from beyond the health sector developed over this time period. These efforts included utilisation review, profile analysis, quality and performance indicators, quality circles, Total Quality Management, and Continuous Quality Improvement. From a very small base in 1984 quality assurance and quality improvement programmes proliferated such that in 1989 there were 1,478 identified initiatives in 116 districts (Carr-Hill and Dalley 1992). These quality initiatives did not attract the level of hostility of resource management and clinical audit as they focused more on management techniques and less on professional competence. Further, these initiatives were voluntary, unsystematic, often the preserve of nursing staff and innovative managers, and left the acceptable standard of care in the hands of individual clinicians.

Quality assurance initiatives were also encouraged by professional bodies. Professional guidance poured forth from the Department of Health, royal colleges, nursing bodies, professional journals, international collegial symposiums, quality assurance experts, and others. The clinical guideline movement, the first professional movement to advocate more explicit control over clinical policy and decision-making (Lomas 1991), was perhaps the best known and most successful of these profession-based quality movements during this time period .

The common factor across all these efforts was lack of overall coherence. Whilst the programmes, advice and efforts may have seemed internally coherent, advice offered by different bodies on the same subject was often contradictory, incomplete or

confusing. (A recent example is the contradictory advice about the use of spirometry in the care for COPD patients contained within the NICE guidelines and the Quality Framework in the new GP contract.) Furthermore, each audit, QA initiative, clinical guideline etc had a different authoritative source that developed its particular initiative in isolation from other initiatives. Within hospitals, methods and interventions were not integrated, implementation efforts were not coordinated, roles and responsibilities were ill defined (Bristol Royal Infirmary Inquiry 2001a).

As the above discussions suggest, the key Griffith's initiatives were limited in their potential partially because complementary strategies in support of them were not sufficiently recognised and prioritised as significant factors in the strategy. Two such support strategies were the establishment and development of the technological bases for information reporting and the selection of a casemix classification system.

Information Systems

Despite the need for reliable clinical and resource information throughout much of the NHS' history and particularly post Griffiths, there was no coherent policy on information systems for the NHS prior to 1992 (NHS Information Management Group 1992; Wainwright and Waring 2000). It had been evident from the early 1980s that, firstly, doctors both recognised the value of clinical information in their work and desired information systems with sufficient flexibility to meet their varying needs (Carter and Magee 1983; Davis and Miles 1984) and secondly, that for useful comparison of the data generated (whether clinical or resource based) the information systems would have to be nationally compatible (Ferguson and Lapsley 1989). However the information systems supporting the varying resource management and clinical audit initiatives were abundant, uncoordinated, and bore no connection to the hospital wide patient administration systems (which were designed to provide throughput information rather than data about clinical or resource usage). This was primarily the result of the fragmented funding systems for the various initiatives, the desire by managers to increase clinical ownership of initiatives by encouraging clinicians to design their own system and the entrenched thinking that isolated clinical and non-clinical matters into isolated domains of authority (Bristol Royal Infirmary Inquiry 2001a; Freer 2005b).

Casemix

Casemix is a generic term for classification systems that group hospital patient activity by similar clinical diagnosis and/or treatments, resource use and other associated criteria. It is used to understand, manage and, in many countries, fund hospital activity on a product basis. Work on a UK version of casemix began in the 1980s by the Clinical, Accountability, Service Planning and Evaluation research group and transferred in 1991 to the National Casemix Unit in Winchester. However the Department of Health failed to support the introduction of the various managerial tools and techniques referred to above and the RMI with a clear casemix message.

Although the RMI databases were casemix based (Street and Dawson 2002), each hospital was free to use whatever casemix system it wanted. Huddersfield Royal Infirmary successfully adopted READ codes "which gave very rich detailed information" on both the clinical process of care and costs (Freer 2005a); other sites used various forms of diagnosis related groups (DRGs). This freedom of choice in the use of casemix was detrimental in two ways. The absence of consistent casemix systems prevented comparability of data across RMI pilot sites ... "you were going it alone, there was no-one to share your results and progress with". Secondly and consequently, it limited wider appreciation of what could be achieved with casemix analysis (Freer 2005a) at both the organisational and national levels, contributing to a continued paucity of product orientation within NHS hospitals.

In the 1990s the Department of Health and Social Security selected health related groups (HRGs), a local variation of US derived diagnosis related groups (DRGs) based on the Korner hospital episode statistics, clinical meaningfulness, and similar resource use (Street and Dawson 2002). Despite this, the possibilities for casemix during the resource management initiative and later the internal market (see below) remained of little significance. In the eyes of the director of the National Casemix Unit at this time, this was attributable to the centralised funding mechanism prior to the internal market and during the internal market, the government's political preoccupation with block contracts to ensure volume activity (Sanderson 2005). Another commented that "despite putting all the returns in, the Korner returns etc, nobody was interested, there

were no other drivers, no natural push for it" (Freer 2005a). Yet others believe technical and managerial failure were partly to blame (Dixon 1998; Light 1998).

Whatever the explanation, the restricted benchmarking role for casemix applications prior to the 2005 introduction of the Payment by Results funding agenda minimised the organisational transparency of clinical work, inhibited a product focus within the NHS and impeded the efficacy of various efficiency and effectiveness initiatives. Even in 2002, researchers working in the Northeast and Yorkshire found that staff in hospital Trusts and PCTs, used to thinking in terms of block contracts, commonly viewed the clinical load of hospitals as an undifferentiated whole. They were unable (without outside assistance) to clearly stratify the clinical load of hospitals and to frame product centred interrogations of the Hospital Episode Statistics as a prerequisite to rethinking service redesign and overall efficiency (Degeling, Maxwell, and Iedema 2004; Degeling, Maxwell, Iedema, and Hunter 2004) (Wickings 1978).

Clinical Directorates

The RMI's impact was primarily, but not solely, upon managerial processes. It also provided a major impetus for structural and cultural change within hospitals via the establishment of clinical directorates (CD). The CD structure first emerged in John Hopkins Hospital in the US in mid 1970, was adopted in the UK initially by Guy's Hospital in 1984. They have since become almost ubiquitous in larger district and teaching hospitals. A CD is an aggregation of a number of clinical departments, wards and units into a formal organisational entity or subunit configured on product line management principles around a disease type. CDs have devolved budgets and are managed by a doctor with managerial qualifications (though many medical clinicians tend to see the CD as a manager with medical qualifications) with the support of a nurse manager and a business manager.

The claimed benefits of the clinical directorate derive from its asserted propensity for overcoming corporate level managers' inability to penetrate the clinical work space, obtain a detailed understanding of clinical production processes and their costs, and thereby gain control of the resource implications of the production side of hospital

activity. By engaging clinicians in management processes and hierarchies at a level closer to the clinical work place, CDs were said to provide the decentralised decision making (Heyssel, Gaintner, Kues, Jones, and Lipstein 1984; Hickie 1994; Sang 1993), reconciling clinical freedom with management authority and accountability, and equating power with responsibility (Fitzgerald and Sturt 1992; Lee, Clarke, and Glassford 1993; Packwood, Keen, and Buxton 1991). These, in turn, were thought to combine to produce a clearer focus on the health service offered, the needs of patients (Lathrop, Seufret, MacDonald, and Martin 1991), and improved efficiency (Braithwaite 1993; Disken, Dixon, Halpern, and Shocket 1990; Ruffner 1986).

However comparatively recent evaluations of CDs and their contributions to hospital performance have found that there is little definitive evidence of these supposed gains (Braithwaite 1999; Braithwaite 2006). The findings applied regardless of whether the issue at hand was the devolution of appropriate authority and power for clinical directors, accountability relationships between CD managers and corporate manages and/or between clinical directors and clinicians, or resource management and audit. Although the evidence tends to suggest that management tasks have undoubtedly been devolved further into the clinical space, clinical directorates, rather than facilitating new ways of working between clinicians and managers have tended to recreate the traditional hospital patterns of authority and practice. The usage of product line management approaches to clinical work within clinical directorates is frequently minimal and doctors remain substantially autonomous in their work practices.

In part, this is the outcome of successful professionally structured resistance aimed at retaining the negotiated power arrangements inherent in traditional ways of working (Boyce 1993); (Braithwaite 2004). However it is also the case that clinical managers such as clinical directors are hampered by the limited availability of management training and a focus on generic management skills rather than the skills required for managing a highly politicised workplace. More particularly, they are hampered by a lack of familiarity with, and use of, casemix management systems (Maxwell, Degeling, Kennedy, and Coyle 2005) and limits on the number of sessions for undertaking management tasks and clinical sessions (Allen 1995; Fitzgerald and Sturt 1992; Mark

1994; Packwood, Keen, and Buxton 1991; Pettigrew, Ferlie, and McKee 1992; Rea 1994).

Chapter Five

An Historical Perspective on Clinician Engagement in Organisational Management

(Up to and During the CMD Project)

The Internal Market

The drive towards simultaneous attainment of efficiency, effectiveness and changed management practices took a dramatic change of direction in 1989 with the separation of purchasers (district health authorities and GP fundholders) from providers. Interactions between the purchasers and the providers were mainly through contracts or service agreements which set out prices, volume and quality of services. The reform aimed to merge the private and public sectors of health care in the sense that health authorities are free to choose providers for any source in order to meet the needs of their resident populations, thus creating incentives for NHS providers to increase their efficiency in providing quality services. In order to facilitate this freedom of choice by purchasers and of response by providers, beginning from 1991 public hospitals were transformed into separate self-regulating legal entities 'NHS Trusts'. The rationale for these decisions was described by Salauroo and Burnes (Salauroo and Burnes 1998), quoting and expanding upon Carr and Donaldson (Carr and Donaldson 1993), as the "belief that a market system would induce positive behaviour [by managers and professionals] which would work in the interest of patients, and that it would bring accountability and value for money within a proper management framework." Clinical effectiveness was to be protected and promoted throughout these reorganisations via teamwork and reorganisation of clinical work; skill-mix reviews, multi-skilling initiatives, job re-evaluations, and process re-engineering became common (Dyson 1991; Unit 1996): "The best and most cost effective outcomes for patients and clients are achieved when professionals work together, engage in clinical audit of outcomes together, and generate innovation to ensure progress in practice and service (NHSME 1993) para 4.3)".

The introduction of the internal market was motivated largely by ideological motives: individualism and its associated concepts of competition, value for money, consumer choice, and a desire for "visible, active and individualistic form of leadership" (Ferlie, et al., 1996) had triumphed in the previous two decades over more socialistic concerns such as equity, need and universalism (Flynn and Williams 1997). It was also likely informed by the relative acceptance of US clinicians to involvement in managing the profitability of their organisations through the use of utilisation reviews, shorter lengths

of stay, more ambulatory and lower cost care alternatives – a willingness that had not been matched in the UK (Ginzberg 1996; Redisch 1988; Stoeckle and Reiser 1992; Winkenwerder and Ball 1988).

The three main areas whereby the NHS internal market reforms might have been expected to influence hospital productivity/efficiency were Trust status and the managerial changes and incentives believed to accompany that, competition between providers, and the rise of a multiplicity of small purchasers (fundholders) in addition to the larger health authorities. Evaluations of the productivity effect of internal market reforms tended to be politically polarised and poorly supported by data (Hunter 1994; Radical Statistics Health Group 1995). Several well known studies of the internal market (Bartlett and Le Grand 1992; Bartlett and Le Grand 1994; Propper 1994; Smee 1995) failed to use casemix based data which may have significantly biased their results. Whereas studies of unadjusted data showed that the transformation from directly managed hospital to Trust status increased costs, a later casemix based study claimed exactly the opposite. Competition between hospitals had only marginal effect on productivity (Klein, Day, and Redmayne 1996) suggesting that either the expected pressure on hospitals to reduce costs did not eventuate or that the hospitals competed on a non-price basis factors such as perceived competence of specialists, waiting times, and access (Culyer and Posnett 1990; Glennerster and Matsaganis 1993; Miller 1994). More disconcertingly from the viewpoint of resource management, in hospitals that had multiple purchasers compared to those that had fewer the transaction costs associated with the need to contract (Klein, Day, and Redmayne 1996) raised average costs. Further, as the National Audit Office reported, the use of block contracts instead of specified product contracts meant patients tended to follow the money instead of vice versa, replicating patterns of provision and resource allocation from the previous globally budgeted and directly managed hospitals (National Audit Office 1995).

The conflicting needs of market oriented organisations for diversity and innovation and the bureaucratic and political needs of the government to retain overall control of the NHS (and the Thames region's financial crisis in particular) resulted in increasing intervention in the management of the internal market. In 1994 extensive national

guidance (Department of Health 1994) was released and the internal market was repositioned as a programme of management reforms using market-like mechanisms rather than competition per se (Ham 1999).

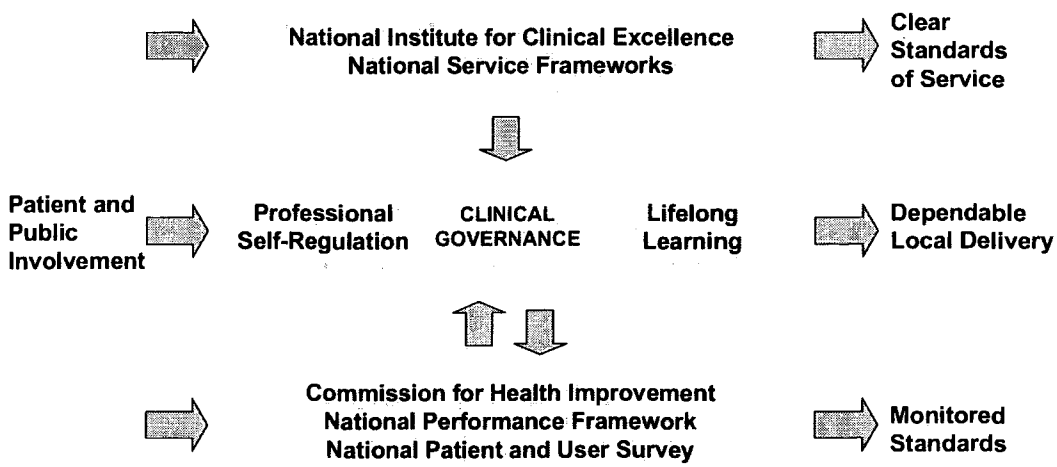
Researchers' conclusions on the impact of the internal market were that it failed to stimulate the expected changes in management of costs, quality and monitoring of care (Ham 1999; Le Grand, Mays, and Mulligan 1998). There were some gains in efficiency, offset by increased transaction costs for Trusts dealing with large numbers of fundholders (see above), and despite a record increase in patient dissatisfaction with the health service (Judge, Mulligan, and New 1997), no evidence of an impact on the technical quality of care. In addition there was little change in consumer orientation especially in terms of patient choice and provider responsiveness although equity of access had declined somewhat. Finally, there was no real difference in service allocation or accountability arrangements. In the internal market's favour there was some evidence that the influence of general managers and clinical managers was increasing (Ferlie, Ashburner, Fitzgerald, and Pettigrew 1996) and that the requirements of purchasing had produced some weakening of the cultural emphasis within organisations on the individual patient towards public health and patient populations (Ham 1997; Ham 1999).

The Third Way

In 1997 'New Labour' came to power committed to a 'third way' of extending the search for efficiency via new funding models, management structures and information systems and a simultaneous strengthening of the emergent clinical performance agenda. The government sought to do this in the NHS using the same broad framework it had put in place for other industries. This was characterised by heavy reliance on regulation as an intermediary mechanism between an unfettered free market and 'monolithic bureaucracy', and on 'partnership, driven by performance', in this case between health care organisations and between health and social care (Bradshaw 2003; Giddens 1998; Ham 1997; Ham 1999; Walshe 2002). Hence the regulatory context of healthcare under new Labour was, and is, much more extensive than under the previous NHS arrangements. In essence and the words of the then new Prime Minister,

these changes were designed to produce a new NHS defined by 'values, standards, inspection, regulation and funding'. The usual corporate governance regulations and requirements were sharpened through a carrot and stick approach encompassing amongst other things performance targets and ratings, access to a new Performance Fund, and the heightened threat of unemployment for 'nonperforming' senior managers. The clinical performance agenda was pursued via the establishment of new national bodies such as the National Institute for Clinical Excellence (now the National Institute for Health and Clinical Excellence) and the Healthcare Commission (previously the Commission for Healthcare Improvement) and locally through the introduction of clinical governance.

Figure 5.1 The Policy Context for Quality Modernisation



Source: Dept of Health 1998

A summary of the early policy arrangements is depicted pictorially in Figure 5.1. The two key interventions designed to define how services for key patient groups should be delivered in accordance with best practice are NICE and the NSFs. The National Institute for Clinical Excellence was established as a Special Health Authority for England and Wales on 1 April 1999. Its remit is to provide patients, health

professionals and the public with 'authoritative, robust and reliable guidance' on current best practice. Its guidance covers individual health technologies (medicines, medical devices, diagnostic techniques, procedures etc) and the clinical management of specific conditions. National Service Frameworks are not organisations but statements of requirement that elaborate minimum national standards and defined service models for a nominated service or care group, programmes to support implementation and measures against which performance can be assessed. They are intended to provide a systematic approach in the drive to improve standards nationally thereby improving equity and quality across health care sectors, in partnership with social care and other organisations, and across the nation ((Neath Port Talbot Local Health Board 2003) Though primary in England and Wales, these are not only the only initiatives that seek to specify minimum standards of care. Such efforts are proliferating both across disease groups, e.g. the national Cancer Plan's Improving Outcomes Guidance, and across organisations with varying degrees of interest and influence, e.g. the Royal Colleges and international disease study groups such as the Global Initiative for Chronic Obstructive Lung Disease (GOLD) which was launched in 2001 following an NHLBI/WHO sponsored workshop.

The Commission for Healthcare Improvement (now the Healthcare Commission responsible for the Annual Health Check for NHS Trusts), National Performance Framework and National Patients and Users Surveys provided a three pronged monitoring arrangement whereby performance, across a wide range of measures including implementation of NICE and NSF guidance, was monitored from the viewpoints of an independent auditor, the Department of Health and end users. These measures externalised arrangements for overseeing clinical work to an extent not believed possible ten years previously (Harrison 2002; Harrison 1989). Further, via clinical governance, Trust managements acquired legislated responsibility for ensuring local implementation of national standards of care, thus supplementing clinicians' individual responsibilities to their peers and their professional bodies' standards with a responsibility to their organisations' management as well. The implementation of structures and processes in support of service redesign and delivery, and clinical

quality assurance and improvement, was expected to be prioritised in line with local health improvement plans (known colloquially as HImpS).

Responsibility for production of these plans rested with new local primary care organisations (primary care groups, now Trusts) which also had responsibility for commissioning care for the local population. These organisations, formed out of the previous internal market's Health Authorities and GP fundholders, were to be led by a Professional Executive Committee comprised of GPs, nurses and allied health professionals and working in partnership with local social services bodies. They were charged with undertaking extensive consultation and partnership with local communities about their health-related needs and desires.

Taken as a totality, these arrangements greatly increased expectations that health professionals became much more explicitly accountable for the design and delivery of services to the Department of Health, the general public, and the local community. The accountability of health professionals (to each other) was also increased through the introduction of required peer review processes and revalidation procedures for doctors announced around this time (though not formally introduced until several years subsequent to the announcement).

The financial and clinical agendas became increasingly interlinked in the government's thinking. A plethora of policy documents outlined how the broad initiatives for achieving the effectiveness and efficiency goals were to be implemented, preparing the way for significant service changes at all levels of the NHS (see for example (Department of Health; Department of Health 1998a; Department of Health 1998b; Department of Health 1999a; Department of Health 1999b). At the broader systems level these policies include the interlinked initiatives discussed above, the redistribution of resources and power into primary care (Department of Health; Department of Health 1998a; Department of Health 1998b; Department of Health 1999a; Department of Health 1999b; Department of Health 2002d), a new casemix based financial framework for acute care (Department of Health 2002c), and attempts to create a 'patient centred' NHS through increased competition (Department of Health 2002a). This included mandatory offering of alternative treatment options to patients by GPs (under the

auspices of the PCTs), the establishment of alternate care providers such as the establishment of the independent treatment centres (Department of Health 2002b), the required awarding of designated percentages of clinical activity to the private sector, and, latterly, Foundation Trusts. These policies can and do provide conflicting incentives. For instance, whilst the drive for commercial success for both acute providers and PCTs, in combination with restricted funding formulas for PCTs and new pricing mechanisms, encourages PCTs to keep activity out of acute providers, it simultaneously encourages acute providers to increase their activity. This is accentuated by Foundation Trusts' ability to operate independently and integrate vertically, bringing primary care inside the acute providers.

At more clinically immediate levels policies have introduced, among other things, new performance based contracts for medical professionals (Department of Health 2005; Dyson 2003), compulsory audit for secondary care consultants (Barnett 2000; Barnett 2001), dissemination of industrially based production techniques such as process mapping and other 'best practice' techniques by the Modernisation Agency. (See for example (NHS Modernisation Agency 2004; NHS Modernisation Agency 2005; NHS Modernisation Agency Demand Management Group 2002). Underpinning many of these policies, and for that reason, the most significant in terms of setting overall direction, has been the NHS Plan (Department of Health).

The NHS Plan

The NHS Plan provided for steadily increased funding of the NHS over ten years and linked this to 'modernisation' of the Service i.e. devolution of responsibility to health professionals for reform of systems and local clinical practice centred around the needs of the patient. Amongst its promises were:

- Significant increases in funding targeted via National Service Frameworks for particular patient/disease groups,
- Patient empowerment through more information and greater choice,
- Changed clinical work patterns, and
- Quality improvement, tougher standards and a system of incentives for achievement.

The Plan outlined a real expectation that clinicians would be involved in management and would take the lead in setting the agendas for their organisations, particularly primary healthcare Trusts. It also laid a clear responsibility on clinicians for transforming the health service at the levels at which clinical work is done, 'Radical changes are needed in the way staff work to reduce waiting times and deliver modern, patient-centred services. This is not a question of staff working harder. It is about working smarter to make maximum use of the talents of all the NHS workforce' (ibid, p82). This included greater emphasis upon multidisciplinary team working, changed role requirements and altered responsibilities e.g. the adoption of prescribing practices and minor surgery by nurses and others, and the expansion of responsibility for clinical management by nurses, midwives, pharmacists, therapists, scientists and health visitors (ibid, pp82-84).

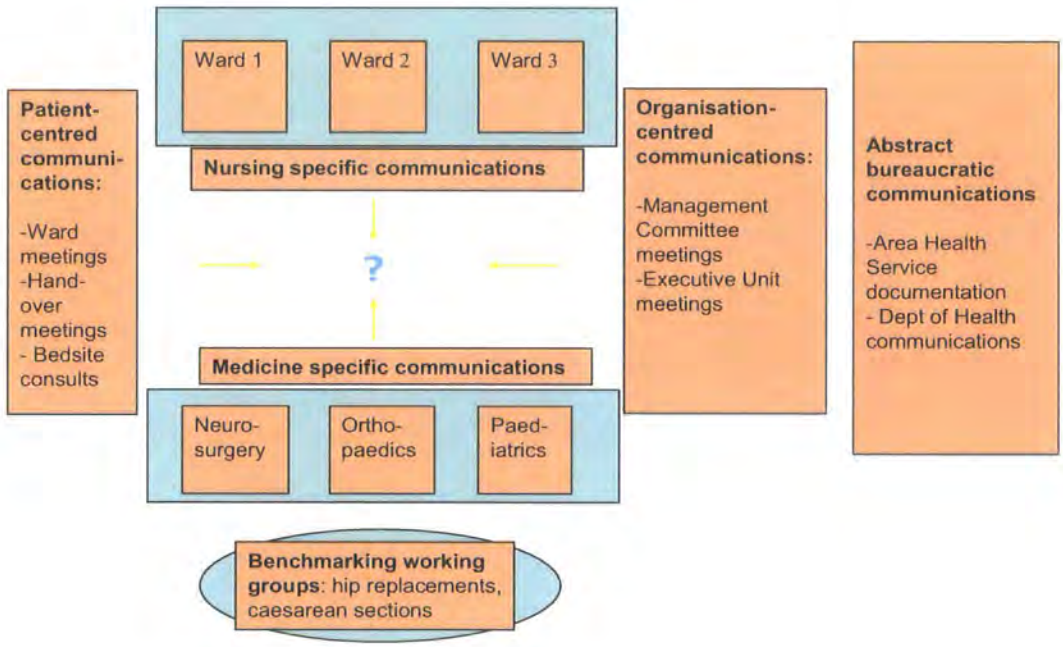
Many participants and observers however would agree that, although there has been some progress towards achievement of the NHS Plan, its goals, particularly at the level of the wider NHS system, are still long way from routine enactment (Freer 2005b; Mullen 2005). The reasons for this are numerous. On an instrumental level, new roles ands responsibilities take time to define, design, develop, assess, disseminate, and locate within career paths, professional standards, accreditation regulations, remuneration packages etc. On a more fundamental level, these changes drive multiple and complex changes into the core arrangements of the traditional NHS. Whereas the earlier consensus decision-making management strategy required multidisciplinary team working only at the most senior levels of organisations, these changes require it at all levels within and even across organisations, from senior management to the clinical shop floor.

Ongoing Impact of Traditional Healthcare Structures and Practices

An extensive body of research has shown relative immutability at practice levels as a consequence of a variety of interwoven factors. As discussed earlier a key element is doctors' fear of an enforced restriction on clinical freedom and an associated renegotiation of clinical autonomy (especially when viewed in the light of the

compulsory appraisal of consultants' work and the GMC revalidation procedures)(General Medical Council and Department of Health 2002), professional defence of narrowly rigid interests (Atkin and Lunt 1996; Audit Commission 1992; Browne 1997; Gough and Richards 1999; Herk, Klazinga, Schepers, and A.F. 2001; McLaughlin 2001; Neuhauser 1991). Other key elements include inadequate larger structures and organisational processes, the incentive structures provided by regulatory and financial arrangements, and broader social and political issues (Griffin 2001; Hunter 2004; Öhman, Hägg, and Dahlgren 1999). Finally, pervasive 'sagacious conformity' i.e. the appearance by staff of having adopted the latest reforms and modernised but avoiding substantive change in order to preserve accepted norms is thought to have been widespread (Bradshaw 2003)p100). This is perhaps an unavoidable tendency given the volume and pace of change (eighteen reorganisations in the twenty years up to 2003), problems in envisaging new ways of doings things, and the lack of national platforms for bureaucrats, clinicians and managers to meet, discuss and find common ground. Though nominally such platforms exist through representative bodies such as the British Medical Association, Royal College of Nursing etc, the problem is more fundamental at local levels. Figure 5.1 over the page maps the limited range of work related discussions, meetings, and conversational foci associated with existing functional conversation spaces within an Australian public hospital organised upon traditional lines common in the UK (Degeling, Iedema, White, Meyerkort, Mallock, Smith, and McLennan 2004).

Figure 5.1 Conversation Spaces in an Australian Functionally Oriented Hospital



Source: Degeling, Iedema, White, Meyerkort, Mallock, Smith, and McLennan 2004 (modified with permission)

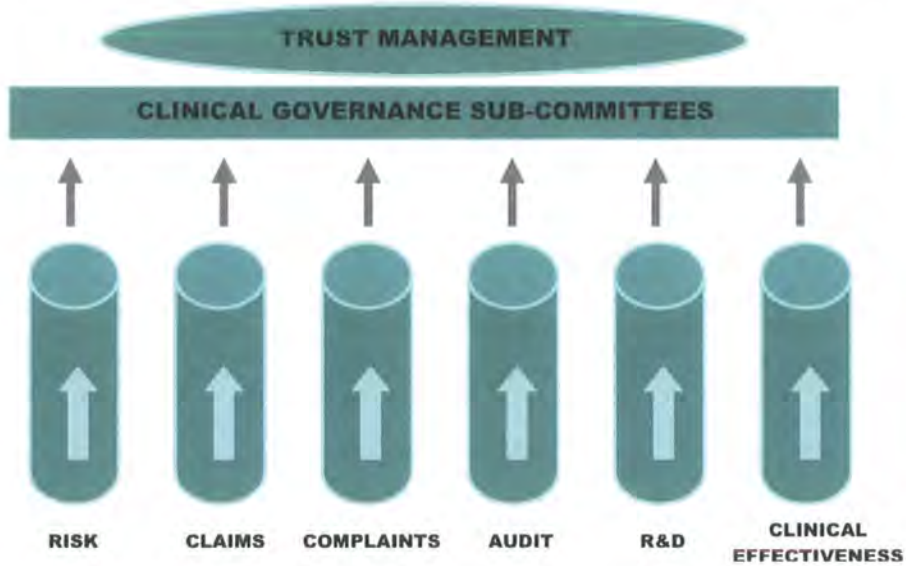
It shows that 'talk' on the wards primarily concerns individual patients on a disciplinary basis. Nurses talk about nursing issues and about individual patients' needs at shift change; doctors talk about individual patients during ward rounds. Medical conversations about medical issues also take place elsewhere and are primarily centred on specialties. Managers talk about organisational concerns in offices elsewhere and, although some of these meetings do bring together some nurses and doctors, the conversational focus is driven by managerial concerns. Abstracted bureaucratic/managerial conversations were also common and specifically located. Crucially, there was no place where representatives from all professions came together at an intermediate and multidisciplinary level to discuss the whole patient journey, devise preferred multidisciplinary treatment regimes for nominated patient groups, discuss roles and responsibilities, or jointly review treatment by all professionals across a clinical condition. Nor was there a forum to provide a logical interconnection between the highly individualised, patient and profession specific conversations of health professionals and the highly aggregated and organisationally oriented conversations of managers and policy authorities. The only place where these types of conversations

could have taken place was the externally oriented benchmarking groups. But these focused on overall activity, length of stay etc rather than the composition of clinical care, its coordination or its outcomes. Finding new ways of working therefore also requires finding new ways of talking, new places in which to talk, and new means for authorising such talk. Without these supports, new initiatives risk falling by the wayside through lack of shared understanding or becoming trapped by the old patterns.

The short history of clinical governance in most NHS Trusts illustrates the point. Clinical governance was conceived as being local in its orientation and its operation. It was designed to integrate financial control, service performance, and clinical quality in ways that will engage clinicians and generate service improvements. It was therefore a mechanism for locally ensuring clinician engagement in the pursuit of efficiency and effectiveness. It was intended to inspire and enthuse and create a no-blame learning environment characterised by excellent leadership, highly valued staff, and active partnership between staff and patients (Degeling, Hill, and Kennedy 1999; Scally and Donaldson 1998). However beyond the understanding that there needed to be a committee that reported to the CEO few, if any, policy makers, bureaucrats, clinicians or managers were clear about what was required for clinical governance to operate in practice. A brief reading of several of the key publications on implementation at the time, including most critically the advice published by CHI (Degeling, Maxwell, Macbeth, Kennedy, and Coyle 2003b), quickly conveys the sense that the commentators were 'talking around the topic' unable to give a definition of the essence of clinical governance beyond a committee structure that reported to the CEO (Goodman 2001; O'Kelly and Maxwell 2001; Swage 2000).

The resulting implementation of clinical governance in Trusts was in keeping with the traditional need of NHS administrators and managers to manage issues and inputs; clinical governance structures adopted throughout the NHS in England and Wales overwhelmingly emphasised the individual components of clinical governance as shown in Figure 5.2.

Figure 5.2 Prevailing Silo Structure of Clinical Governance



Clinical governance infrastructure dominated by traditional retrospective and reactive 'silos' (risk, claims, complaints, audit, health and safety)

Source: (Degeling, Maxwell, Iedema, and Hunter 2004)

The resulting silo structures meet the formal arrangements required by government but their focus is upon individual issues. These issues based reporting structures currently in place (risk management committees, professional education committees, quality assurance committees, complaints committees etc) do not equip or support clinicians to consider the full range of clinical, organisational, and interpersonal processes that are entailed in treating a patient with a chronic disease or requiring coronary artery bypass graft. Rather than supporting the coordination of care components and the integration of clinical and organisational aspects into a coherent framework they dissect the clinical process into abstracted issues, none of which can be satisfactorily addressed in isolation from the components and the wider internal systems of care providers. For example, it does not assist a cancer care team to monitor the components, timeliness, coordination, effectiveness, efficiency, and safety of care for patients undergoing treatment for cancer. Nor does it assist clinicians identify and minimise the system errors underlying an estimated 59% of adverse events in other Western health care systems (Wilson, Runciman, Gibberd, Harrison, and Hamilton 1996).

Thus the current structures of the NHS, even within clinical directorates, continue to reproduce two core absences in the NHS – the lack of a clinical product focus and the lack of platforms from which to develop it. This prevents the prospective integration of the components of clinical work and governance at the level at which clinical work is actually carried out. 'Governance' of clinical work becomes another enactment of the traditional separation of managers and clinicians; it is a managerial exercise with little direct clinical relevance and providing little evidence about where either efficiency or effectiveness improvements should be directed. This diminution of the potency of clinical governance has been further compounded by the (anecdotal) tendency for Trusts to structure the content of clinical governance activities, such as clinical audits, complaint investigation and staff development, around whatever needs to be done to achieve the latest performance targets. It has not been used to develop a clinically prioritised and systematic analysis of how clinical work is organised, performed and assessed. The inspection changes that accompanied the amalgamation of various inspection agencies into the Healthcare Commission and its introduction of seven key pillars of corporate performance (safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, public health) have gone some way in remedying this. However formats for multidisciplinary working still tend to have to work across the grain of traditional healthcare patterns.

Pursuing Clinical Engagement in Management

Clinical engagement requires clinicians to see the value for their patients and their own work experience of greater involvement in management. Efforts to increase clinician participation in the wider activities of the organisation will therefore need to pursue strategies carefully designed to create 'space' for conversations that link patient and organisational concerns, draw clinicians into wider conceptions of clinical work, its conduct and its management. Achieving the deep structural and practice change required to facilitate "conversations" requires careful, even inspirational, renegotiation of existing practices within a coherent and professionally acceptable framework (Degeling and Carr 2004; Degeling et al. 2003a; Ham 2003). Specifically it requires understanding and coherent action on three fronts; firstly, what motivates professionals in their daily work, secondly, about methods for achieving an integrated,

multidisciplinary approach to care delivery, and thirdly, in developing organisational structures that will support multidisciplinary professionals in designing, delivering, reviewing and improving care. On the first of these, research has shown that achieving change in NHS organisations most often requires that doctors and their clinical colleagues can see benefits for their own practice and for patients, that they have a sense they are leading the change process rather than being driven by it (Bowens and McNulty 1999; Ham and Hunter 1988; Joss and Kogan 1995); financial reward is a secondary, though strong, motivation. A demonstrated potential for achieving improvements in the quality of care is also a potent motivator for professional acceptance of the need for organisational and process change (Chantler 1988; Walshe and Offen 2001).

Integrated Care Pathways as a Means for Clinician Engagement

As mentioned earlier in this work, one potentially useful method for achieving integrated multidisciplinary approaches to clinical work is more routine use of ICPs. The definition of ICPs has been evolving over time with growing understanding of their potential consequently there is no one agreed definition of an ICP. The Department of Health uses a privately copyrighted definition that fails to include any reference to the financial dimension of clinical work. However the literature in total suggests that the concept of ICPs is maturing towards a definition as systematically developed written statements of the agreed sequence of the phases and events of care for specified clinical conditions that, in the view of clinicians (medical, nursing, allied health) and managers and in light of the available evidence, resource constraints and experience of patients, are essential for achieving nominated outcomes. They are developed in the light of available evidence, stated resource constraints and experience of patients about which care events are essential for achieving nominated outcomes for specified clinical conditions. Quality and outcome indicators are incorporated into the pathways. The delivery of care is routinely recorded and performance is assessed against these specified standards for the sequencing, delivery and outcomes of care.

ICPs were initially strongly advocated in the nursing literature (Borokowski 1994; Del Togno-Armansco 1993; Guiliano and Poirier 1991; Johnson 1997; Selwood 2000;

Zander 1988a; Zander 1988b). Increasingly, the medical literature also reports an extensive array of benefits to patients and health professionals from such techniques (Armon, MacFaul, Hemingway, and Werneke 2004; Board, Brennan, and Caplan 2000; Gendron, Lai, Weinstein, Chalian, Husbands, Wolf, DiDonato, and Weber 2001). A growing body of evidence suggests that benefits include a strengthening of the evidential basis of clinical practice and outcomes, improved patient and professional communication, improved clinical risk assessment, improved care delivery, and resource savings without adverse clinical impact. (For examples (Ellis 1997; Ellis and Johnson 1999; Jones 1999; NHS National Electronic Library for Health 2005)). A large multi-site study of the organisation and management of care for various clinical conditions found that sites that had implemented clinical management methods oriented towards ICPs had better clinical and resource outcomes than sites with lesser ICP orientations (Degeling et al. 2000b).

Although they specify the agreed outline of care, ICPs are not immutable documents setting out inviolable treatment regimens. When the care process varies from that described in the pathway, the reasons for the variance are recorded and analysed. The analysed variances, together with any changes in organisational circumstances, become the focus of structured across-profession conversations regarding:

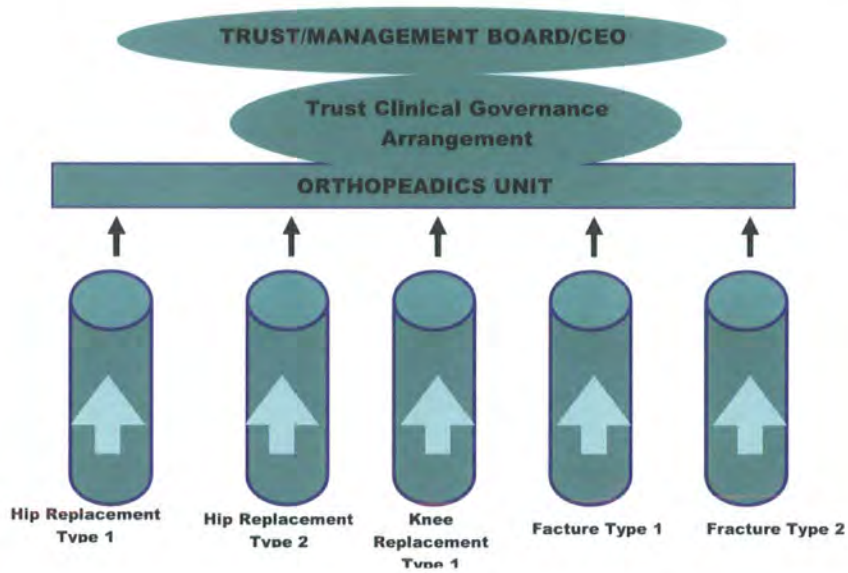
- The points and extent to which the care being provided for this condition varies from that outlined in the clinical pathway,
- The direction and extent to which these variations have affected service integration, the experience of patient, quality, safety, risk, clinical effectiveness and technical efficiency,
- The clinical, organizational and behavioural factors that produced these variations,
- Whether the variations are best resolved (or in the case of beneficial variations, routinely adopted) by changing the clinical, organisational or professional environment or by changing the pathway.

Thus an ICP is more than a document about a series of care practices. It's a piece of information technology specifically designed to enable clinicians, in a time period as close

cluingto real time as is sensible given the volume of cases, to jointly retain and improve control over both the conduct and outcomes of their work. For this reason, ICPs appear to be a key element in successful reform of the NHS. Further, by specifying of the conduct, organisation and products of clinical work yet allowing clinicians to exercise autonomy and clinical judgement to vary from the pathways (including withdrawing patients from pathways) and recording their reasons for so doing, ICPs should enable greater understanding by management of clinical decision making processes and greater understanding by clinicians of the wider implications of their care activities. Such understandings should help to bridge the ideological clash between clinicians and the NHS healthcare management. Moreover, since they include and raise the profile of healthcare professionals who have traditionally been the handmaidens of medicine, namely nursing and allied health professionals, they also contain the potential to address resolve some of the tensions between clinical professions. In summary, ICPs provide a 'shop floor' means for ensuring all relevant practitioners are included in healthcare debates, discussions, design, development, delivery systems, and devolved governance of the care they jointly provide.

However for this to occur, ICPs will need appropriate authorisation and coherent institutional structures within which to embed them. Despite the growing use of ICPs in the NHS, the traditional structures, designed to enforce professional separation, tend to enable only piecemeal or individually championed approaches to pathways (Sorensen 2002). Refocusing clinical governance around ICP based structures provides one way of providing support. Examples of how this might be done are provided in Figured 5.3 and 5.4.

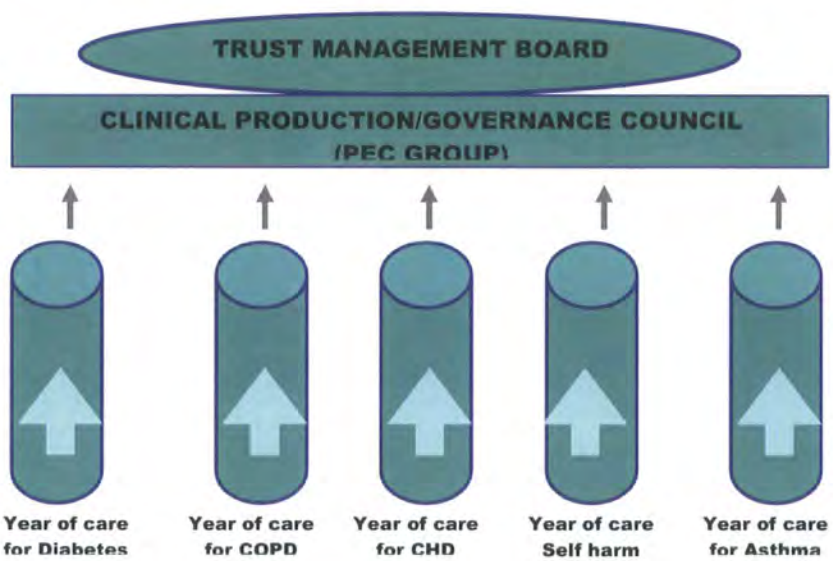
Figure 5.3 ICP-Based Clinical Governance Arrangements in Acute Sector



Each condition/treatment specific report includes data on evidence, cost outcomes, clinical effectiveness, quality, safety, adverse events, variance, complaints/claims

Source:(Degeling, Maxwell, Iedema, and Hunter 2004)

Figure 5.4 ICP-Based Clinical Governance Structure in Primary Care



Each condition/treatment specific report includes data on evidence, cost outcomes, clinical effectiveness, quality, safety, adverse events, variance, complaints/claims

Source: (Degeling, Maxwell, Iedema, and Hunter 2004)

Some issues regarding organisational support for this approach will need to be addressed at a level once removed from the direct performance of individual instances of clinical work, such as 'Who has responsibility for implementing ICPs? Everyone and

hence no-one? Or is there a first among equals?', 'How could an ICP clinical management system be naturalised within and across organisations?' and 'What then is the role of officially designated clinical managers?'

An immediate issue here relates to competency and education for both clinicians and managers. A large number of doctors (and other health professionals) move into important and generally part-time managerial and leadership roles with little, if any, management training[99]. Further, traditional managerial training emphasises generic management traits such as budgeting and personnel management. These skills are of use in managing the inputs of a clinical department (funds, staff etc) but they do not equip health professionals to conceptualise 'doing' clinical work on the product line basis that ICPs provide.

Market research conducted for new postgraduate courses in clinical management, designed to provide these types of skills, revealed that although clinicians were beginning to recognise the need for these types of skills, few senior managers saw the importance of the distinction. Senior managers and CEOs were reticent to support skills in producing a product focused approach to clinical management preferring to send clinical staff on generic management programmes such as Masters of Business Administration (Woodholm and Associates 2005). Despite common acknowledgement that doctors, by and large, simply aren't interested in abstracted concepts divorced from their clinical underpinnings, and that this has repeatedly thwarted the ambition of successive governments to attract the medical profession into generic managerial posts, managers continue to see the problem in terms of lack of knowledge (Bradshaw 2003). But the lack of knowledge is two-sided. CEOs appear to have taken on Griffiths' recommendation that the NHS should invest in the types of work measurement and evaluation systems, performance targets and customer focus without a clear idea of how to achieve these. They tend to see these initiatives as stand alone issues, missing the product management emphasis which is core to success in other businesses. This failure to see the deeper connection between clinical and managerial provides another demonstration of an entrenched functionality in the NHS mindset.

Beyond the immediate concerns of the delivery of care for specified clinical conditions and patient populations, a whole systems approach to healthcare requires clinicians and clinical managers to have considerable understanding about healthcare organisations within their local health economy and region. But, as noted above, the NHS is moving away from a conception of itself as a unified organisation. This tendency is gathering momentum as Foundation Trusts become more common and the competitive ethos becomes more embedded. Implementing the changes envisaged in the NHS Plan requires clinicians and their managers in both primary care and NHS Trusts to understand the roles of other organisations, the values of health professionals working in different settings, and the needs of patients. Having understood these, the Plan requires staff to work together for the patients' best care. By focusing on the work to be done rather than the larger environments and building from there, ICPs offer a potential means for coordinating this efforts at the level of patients rather than the previous pattern of attempting to coordinate services at a level distanced from delivery.

The above discussion provides an example of how ICPs can embed and naturalise clinician engagement in the wider policies of the NHS, simultaneously linking efficiency and effectiveness across the various agendas. As the discussion above has outlined, effective operational management within and across NHS organisations is foundational to the success of the NHS Plan and the modernisation of the NHS. Recognition of this in a more competitive environment will assist organisations in pursuing improvements in timeliness, appropriateness and access to quality care, ideally providing a better service for the same price. Pathway based clinical management links these concepts by providing the framework for specifying what care can be provided, by whom and where.

PCTs can fulfil their responsibilities for clinical standards and service improvements by setting parameters that define 'acceptable' pathways of care and (therefore) 'acceptable' providers from which services will be commissioned. Patients can then choose a service provider based upon specified standards of care and outcomes and factors relevant to their personal situations such as convenience of location, waiting times and care support. This has the additional benefit of allowing PCTs/GPs to offer

considered, yet constrained, choice. A capped number of organisations with whom PCTs (or associated GP practices) will negotiate should produce the additional benefit of reducing transaction costs in service commissioning (although the drive for patients to have complete freedom in choosing a care provider significantly erodes, if not obliterates, this potential).

Success in these activities however requires the active involvement of patients, their families, and all relevant clinicians and other care providers in systems development. There is accumulating evidence to suggest that the hierarchical imposition of externally developed systems will result in failure to achieve what is expected. The evidence comes from the:

- Common failure of change programs to produce the desired changes within more goal coherent commercial organisations (Pratt, Gordon, and Plumping 1999),
- Poor returns from major IT development projects, despite the productivity and service improvement claims made for them (and the high hopes and vast capital invested in them) (Landauer 1995), and the
- Fact that technical failure accounts for only about 20% of 'failed (IT) projects' (Gad 1995).

Failure in the remaining 80% of unsuccessful projects is therefore attributable to a melange of social/historical, cultural, psychological, political, professional, legal and work practice based factors that shape the conduct and structuring of relations in the work settings (Gad 1995). In health settings these include, at least in part, the undermining of the functionality of the policy community by a failure to adequately include patient groups at senior and local policy setting levels (Salter 2001).

Because of all these influences, it is imperative that clinicians have significant involvement in the design, development, implementation, use and governance of systems, including information systems, that are (supposedly) designed to support their work (Ham, Kipping, and McLeod 2003). Together with patients, they are the people best placed to map the complex range of factors that are integral to service provision,

identify their requirements, and design and implement required improvements. Thus, whether the focus is information support, design and management of care provision, or new accountability structures clinician involvement is crucial to success.

Summary

Several policy strands provide impetus towards a coordinated product-based approach to care delivery and management. These approaches are widely utilised in the competitive US managed healthcare industry for several decades to integrate effectiveness and efficiency albeit primarily from a profit motive (Johnson and McGinty 1989; McCormick 1991; Ruffner 1986) (Savary and Crawford-Mason 2006). At the UK national level these policy strands include the disease management and practice foci of the National Institute of Clinical Excellence, National Service Frameworks, and some initiatives from (the former) Modernisation Agency's. The commissioning function of primary care Trusts offers a more local mechanism for this particularly when combined with internal organisational structural initiatives closer to or at the clinical level. These initiatives extend from a more developmental model of clinical governance, through disease-specific local 'collaboratives' and 'networks', a range of process related initiatives, the NHS National Electronic Library for Health's collection of ICPs, and the provision of information technology providing IT support for ICPs. Taken together, these initiatives have the potential to support a movement towards more integrative, product based approaches to healthcare management.

However the Labour government has been criticised for producing disconnected policy initiatives rather than coherent policy (Calman, Hunter, and May 2004; Gray 2004) and in recent years this criticism has been perhaps more apt that it was previously. The criticisms have some validity in that, although most of the fundamentals for a professionally led, product focused approach to healthcare and hospital management are in place, DoH policies, organisational management structures, and shop floor practices still operate fundamentally within the traditional mentality and structures of issues-based functionalism and tripartite professionalism. It is apparent that, within almost every policy initiative, opportunities to integrate efficiency and effectiveness concerns and to facilitate greater professional involvement in the management of the

NHS through the use of product focused management approaches are not recognised and capitalised upon. The failure by the NHS to capitalise upon these incentives appears to stem from multiple sources. At the Departmental and Strategic Health Authority levels these sources include 'mechanistic and reductionist thinking' consequent to the need for governments to retain command and control of a highly politicised public sector institution (Chapman 2004) and a lack of experience in real world delivery by the centre (Select Committee on Public Adminstration 2003). At an organisational level these sources include the impact of a pervasive target culture still substituting for real commercial thinking (Straughan 2003), a lack of organisational learning (Brunnson and Olsen 1993; Meyer and Rowan 1971) which contributes to sagacious conformity, and an entrenched functionally in the NHS mindset associated with an inability to see beyond the realms of current practices. Specific, purposeful, and mutually coherent policies across all levels of the NHS in pursuit and support of improved management of care, its coordination and outcome for patients and their families are needed. Without these, the likelihood is that effective care coordination will remain a relatively piecemeal practice - a few case managers here, a few pathways there - with patients and families providing the glue that holds their care together.

Chapter Six

Two Trusts

Introduction

When similar projects have dissimilar outcomes in two organisations several questions immediately come to mind. Among these are: How similar are the two organisations in histories, context, and structures? Do differences between these predispose success in one Trust and not in the other? This chapter therefore examines the recent histories, contexts, and relevant initiatives within the study Trusts to begin to address these questions.

The chapter shows that at face value the two Trusts were/are similar in many ways. They are both relatively large Trusts providing general district hospital services on two sites. In each case one predecessor Trust had a reputation for strong fiscal management whereas the second predecessor Trust transferred a significant debt into the new Trust. The study Trusts also each had a predecessor Trust which had been one of the six national pilot sites for the Resource Management Initiative in the late '80s. Hence both Trusts had longer experience than others in enticing doctors into greater managerial responsibility. Both Trusts were structured around clinical directorates. Although they interpreted these differently, the Trusts had similar expectations about what the clinical directorate structure was expected to achieve. Both were/had participated in a well funded, NHS management-authorised, three year research and development project to 'modernise' care delivery over and above that available to other trusts in the NHS.

Form an outsider's perspective, the Trusts differed from each other most clearly in terms of their immediate communities. Yorkshire as a region has experienced much more sustained immigration over the past 50 years than has the northeast. The local communities which the Calderdale and Huddersfield Foundation NHS Trust serves have become much more ethnically mixed than many in the northeast and, in this regard at least, have experienced a greater degree of change. The second aspect of difference between the two trusts related to the intensity of local political activity. For the last ten years many local communities in the northeast have been represented at national level by local members of parliament with senior governmental responsibilities. These local members are not always averse to what locals sometimes regard as

'interfering' in significant local institutions though the motives for this 'interference' may be variously attributed to selfish re-electioneering, politicians doing their 'thing', and to genuine desire to make a positive difference locally. The influence of the local member has been more marked in Hartlepool than in most communities due to the prominence of his national and European roles, his close friendship with the former Prime Minister who held the adjoining electorate, and his personal style. This influence was a significant contributor to ongoing reviews of service provision within the Tees Valley region. At the commencement of the CMD project, all NHS organisations in the Tees Valley were participating in the Tees-Wide Review of services which was expected to recommend realignment and redistribution of acute hospital services north and south of the River Tees. Subsequent to this review North Tees and Hartlepool NHS Trust was subject to two other reviews of acute services; the third of these, the Darzi review, was, rightly or wrongly, attributed by many locals as having been instigated by the member for Hartlepool on purely political grounds.

At the outset of my research the structural similarities between the Trusts appeared more significant in terms of potential research findings than the differences. The periodic reviews in the Tees region seemed to be simply more obvious manifestations of the highly politicised operating environment common to all north east Trusts with which I had worked in some capacity. Further, during the conduct of the CMD project, staff in Calderdale and Huddersfield Foundation NHS Trust had described their own experiences of managing difficult local politics. Thus the key factor for this dissertation was that the similar histories and structures of the two study Trusts suggested neither Trust was predisposed towards success in changing how clinical work was organised and coordinated than the other. This, in turn, suggested that the difference in outcomes was more likely to be the result of internal factors (structures, strategies and processes) associated with the management of the organisation as a whole and with the management of clinical work.

Despite their apparent organisational similarity, the Trusts did adopt different approaches to the management of key events and activities in their recent history, particularly managerial processes immediately prior and subsequent to amalgamation.

These differences appear to be crucial to the manner in which senior management operated, to the progress of the Clinical Management Development project within each Trust, and to how each Trust approaches the coordination and management of clinical work.

Calderdale and Huddersfield NHS Foundation Trust

Overview of Services and Location

Calderdale and Huddersfield Foundation NHS Trust (CHFT) formed in April 2001 following the merger of Calderdale Healthcare NHS Trust and the Huddersfield Healthcare Services NHS Trust. At amalgamation it provided 24-hour acute (general district hospital) services on two main sites, the Calderdale Royal Hospital, Halifax (CRH) and Huddersfield Royal Infirmary, Huddersfield, (HRI), and a mixture of community and inpatient services at St Luke's Hospital, Huddersfield (SLH).

Halifax and Huddersfield are approximately 8 miles distant north-south as the crow flies. They are divided geopolitically and psychologically by a high ridge which runs north-south along which the M62 travels and which also marks the boundaries of the Metropolitan Boroughs of Calderdale and Kirklees. The Calderdale Royal Hospital (CRH) is approximately one and a half miles south of Halifax town centre. The hospital opened in April 2001 (on the same day as the amalgamated Trust began operations) and replaced the existing hospital on that site, the Royal Halifax Infirmary and Northowram Hospital. It was constructed through a £76m PFI arrangement; the physical asset is owned by the Catalyst Healthcare consortium and is maintained by Bovis Lend Lease Facilities Management Division. Non-clinical services including cleaning, catering, laundry and linen, car parking, security, switchboard services and portering are provided by ISS Mediclean. Calderdale and Huddersfield NHS Foundation Trust is responsible only for the provision of all clinical services. This arrangement has led to greatly increased facility costs at the CRH site.

The Huddersfield Royal Infirmary (HRI) is approximately three miles west from Huddersfield town centre. The hospital opened in 1965 and is owned and maintained by the Trust. The main hospital building has not aged well despite several upgrades over the

years which have also enabled the establishment of new clinical and staff services, specialist wards, laboratory services, and a new pharmacy manufacturing unit.

St Luke's Hospital was built in 1965 is situated a few miles south of HRI. In 2007 the St Luke's site provides collocated services for South West Yorkshire Mental Health Trust, Huddersfield Primary Care Trust (previously South Huddersfield Primary Care Trust and Huddersfield Central Primary Care Trusts) as well as CHFT. Services provided here by CHFT include elderly complex care (73 beds), dietetics, neurophysiology, physiotherapy, speech and language therapy, rehabilitation, wheelchair services (which covers Huddersfield & Dewsbury), X-Ray services (primarily for direct referrals from GPs), and some outpatients services.

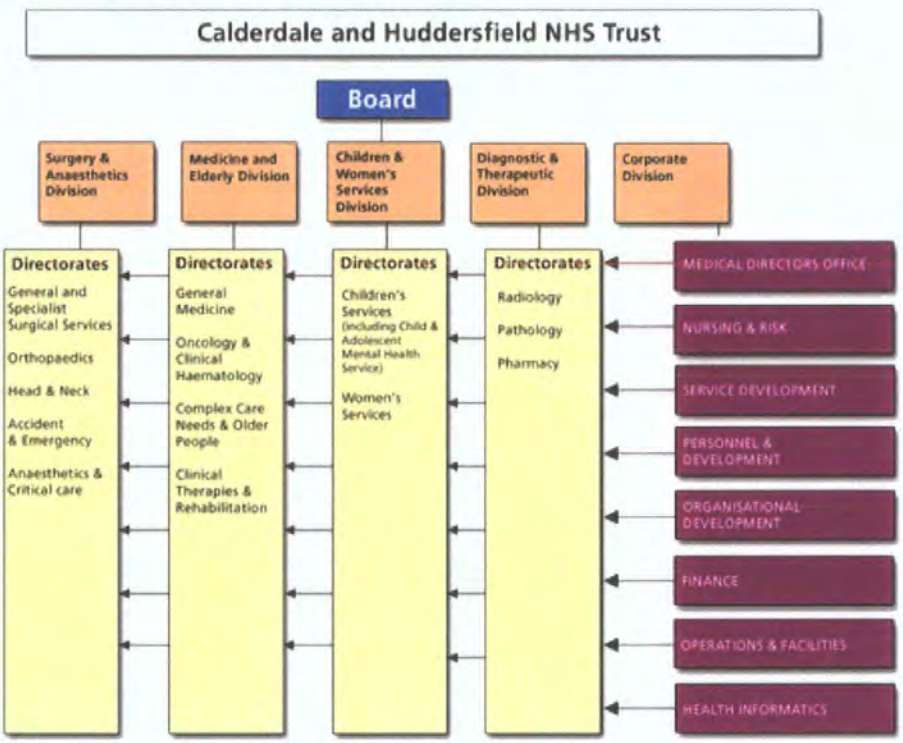
(The establishment of three local primary care Trusts, Calderdale PCT, Central Huddersfield PCT and South Huddersfield PCT and a mental health Trust one year after amalgamation, in April 2002, meant the Trust underwent a further significant restructuring at this time. Many of its experienced staff who provided mental health services and services in the community were transferred to the newly formed Trusts. The establishment of the PCTs meant that the Trust needed to coordinate its services between and across six organisations, each with its own priorities and statutory requirements, clinical priorities and internal agendas. These organisations are CHFT, the three PCTs and two local authorities, one centred in Huddersfield and one centred on Halifax.)

The Trust initially bid for Foundation Trust status in 2004 however the bid was deferred to due to technical financial issues arising in large part from the inherited debt and the financing terms entered into by a predecessor organisation to finance the development of the CRH. In 2007 the Trust provides services to more than 420,000 people, has approximately 5,300 staff and an operating budget of just over £200 million. Some services, especially its informatics services, but increasingly also some of its clinical services, are shared services operating across the Calderdale and Huddersfield health economy which includes the Primary Care Trusts and Mental Health Trust. Most of these shared services are managed by CHFT.

Organisational Structure

Figure 6.1 overleaf shows that the Trust is structured into five divisions, four clinical divisions and one corporate division.

Figure 6.1 Organisational Structure of Calderdale and Huddersfield NHS Foundation Trust *Source:http://www.CHFT.nhs.uk/



The clinical divisions, further divided into various directorates, are Children and Women's Services (maternity, gynaecology and children), Medicine and Elderly (which includes cancer, heart problems, diabetes, services for older people and therapy services), Surgery and Anaesthetics (including theatres, intensive care and Accident and Emergency), and Diagnostic and Therapeutic services (including pharmacy). The fifth division contains the corporate directorates that support the overall running of the organisation. These directorates have both centralised functions and teams located run across the clinical divisions hence, as well as having a central location, some members of this division are also located in each of the clinical divisions (shown diagrammatically as arrows directed into the clinical divisions). These include finance managers and the clinical governance teams. In a subtle but significant symbolic accenting of the website's proclamation, "the focus of the Trust is on clinically-led services with consultants and clinicians taking the lead role in the management of the organisation",

the Trust's web pages outline the clinical divisions before corporate division is even mentioned.

The operations of the Trust are overseen by the Trust Board (supported by various committees including an Audit and Remuneration Committee). The Board ensures the Trust both has a clear strategic direction and fulfils its statutory responsibilities in relation to finance, governance, clinical quality and partnership working. It also plays a part in validating the performance of the organisation via the Executive Management Board (another sub committee) which is responsible for developing and operationalising strategic and business service objectives in response to local needs. The Executive Management Board is comprised of the Executive Team (chief executive, medical director, director of service development, director of nursing, director of finance, director of IM&T, director of personnel and development, and head of organisational development) plus the medical directors of each division. This Board is underpinned by the Clinical Management Structure (CMS), Clinical Modernisation Forum (CMF) and various (functional) Standing Sub-Committees such as occupational health and safety etc.

The CMS is the formal organisational arrangement for managing clinical work hierarchically within the Trust. It is essentially a series of management triads (medical, nursing and general management) devolved through out the organisation. Each division has a triad management arrangement as does each directorate within each division. Within the directorates are multidisciplinary clinical teams. This devolved clinical managerial structure was created at amalgamation by the CEO with an aspiration to promote a culture in which clinicians are at the heart of decision making, establish a common clinical management across the two hospitals, and align and integrate work flows across sites and divisions. Reducing unnecessary duplication in services and variation in clinical practice, and improving the coordination of clinical work, were seen as key contributions to the attainment of these goals. To this end, a series of regular meetings between clinical and general managers was introduced. The divisional managerial triads meet monthly to discuss basic operational performance such as finance and activity. Every six months they meet to discuss performance against all

required indicators i.e. the basic operational indicators plus patient safety, complaints, mortality rates, etc. Since 2005, they also discuss clinical pathways in terms of the efficiency and effectiveness of the current patient journey, how performance on this can be better measured, and whether additional clinical conditions should be pathwayed. Within the Divisions the assistant (general management) directors meet monthly whilst the directorate triads meet quarterly. Once a year the Divisional triads meet (individually) with the Executive team to discuss all aspects of divisional performance.

The CMF operates in tandem with the CMS. It is a series of clinical meetings across the matrix, attended by clinicians and clinical managers to discuss and agree matters which cross the divisions. There are also regular meetings between the divisional and directorate triads and other senior health professionals across the wider health economy. Other matrix meetings for clinicians occur on an ad hoc basis as needed. The CMF was formally introduced subsequent to the Clinical Management Development project (March 2002-March 2005).

The chief executive of the combined Trust was appointed in March 2001. She previously had been chief executive for Huddersfield NHS Trust for four years and has had more than 25 years experience in the health service, included working in the North West and in the West Midlands. Once appointed the CEO decided, with the Board's agreement, that members of the Executive Management Board should be drawn from the two predecessor Trusts and that (as far as realistic given competency requirements) senior management positions across the executive and the divisions should be drawn equally from the two previous Trusts. All senior organisational and clinical managers would be responsible for operations Trust-wide i.e. there would be no site specific management. She also suggested (but did not require) that each new appointee's office would be located on the alternative site to that from which they had previously operated. Despite the voluntary nature of this suggestion, the senior managers adopted this practice. Administrative offices followed the senior managers and senior management and Trust-wide meetings rotated between the Huddersfield and Halifax sites. (Five years down the track all but two executive managers have relocated back to HRI due the difficulty of getting the senior management team to

function smoothly when they were geographically separated. The four divisional managements however are split between the two sites.)

These decisions were taken in recognition of the powerful symbolic statement they made regarding the intention and commitment of the Trust's senior management to create an integrated and united organisation. The arrangements implied that no site was 'better' than the other and that favouritism based on previous work relationships would not be acceptable. It also put the managers in good stead for future reviews and potential reconfigurations of clinical services (as managers would not be asking clinicians to do something that they had not already done themselves). The immediate outcome for various departments was not popular amongst all staff but there was a grudging recognition within the Trust that this was a 'fair' arrangement.

Vision and Values

At the commencement of the CMD project (2002) the Trust's vision (as presented on its website and in various community oriented Trust publications) was summarised as:

"Our ambition is to be the hospital and employer of choice. To achieve this, our underpinning vision and values are:

- Ensuring our clinical processes are patient centred,
- Attracting and keeping the best staff,
- Developing strong leaders at every level who practise and encourage healthy behaviours,
- Creating partnerships and improving collaboration with others,
- Having clear arrangements for the development of policy and strategy,
- Having clear performance management processes."

Three guiding principles for implementing the amalgamation of the two Trusts into a unified corporate body were adopted - 'services, not sites', devolution, and clinical partnership (with management).

At first glance this first vision statement may appear no different to that of many organisations, whether in the NHS or elsewhere except perhaps to say that these are

not values per se but strategies for achieving (unspecified) values. However it could be argued that this vision focused on the organisation in a self-serving way. There was no mention of who are the intended beneficiaries of the Trust's goals, the values to be demonstrated in how those beneficiaries are to be treated, or the principles guiding decisions whether on a strategic basis or in day to day working. The statement could just as be easily be construed as a statement of senior managers' goals to ensure their own performance or to ensure the smooth running of the organisation and management of staff as anything to do with patients or the provision of healthcare services.

In 2005 the Trust changed its vision and value statements to:
"Providing The Best for Our Patients: At Calderdale & Huddersfield NHS Foundation Trust our aim is to provide the very best care for patients. This will mean that:

- We provide safe care in a clean environment,
- Your care is designed to meet your needs, not ours, and delivered as close to your home as possible,
- Our staff are competent and compassionate, friendly and welcoming,
- We work together with you, your family and carers to help you take responsibility for your health and wellbeing,
- Our treatments are up to date and we embrace change, innovation and new technologies to make sure we remain at the leading edge of care,
- We are part of the communities we serve, working together to create and sustain health and wealth for the future".

A motto was also adopted "Your Choice, Your Health, Your Care".

These changes in the vision and values statement of the Trust put the emphasis much more squarely on the needs of patients, the values to be demonstrated in caring for patients, principles for both guiding strategic and operational decisions, and stating a commitment to be part of, and to serve, the local communities. It clearly conveys a belief that the Trust exists only to serve the local community through meeting the health needs of the citizens, to the best of the staff's ability. When the Director of Organisational Development was asked about the rationale for the change (to verify my

interpretation of what was being conveyed in the two vision statements), she volunteered that the original vision statement was a part of a three year strategy to create a new organisation. Towards the end of the three years the Trust undertook an extensive (eventually almost two year) consultation with staff about where they wanted the organisation to go in future and how they wanted it to represent itself.

This commitment to patients is amply demonstrated on the Trust website. Its pages portray an open and transparent organisation giving considerable thought and attention to patient needs. Thus the Trust's website contains explanations for decisions that patients might find questionable e.g. visiting hours are not just listed but explanations are provided of why visiting hours are restricted. It provides an extensive list of links to other health organisations, patient support groups, health advice including nutritional advice, organisations providing help for victims of domestic abuse, clinical policies, contact details for various government departments and much else. In addition the Trust makes various documents available on its web pages regarding its own performance and strategies, including its Annual Reports, 'Core and developmental standards declaration' to the Healthcare Commission, Board minutes, and Foundation Trust and Patient Services Plans. The web site also provides photos of senior managers and Board members as well as information about their responsibilities, backgrounds and special interests. Detailed information about the structure of each division and the services, strategies and key personnel, including all consultants within each directorate is also provided.

One final signal towards the priority of patients' views is that the Trust's management has recently decided to abandon efforts within the two local communities to 'rebrand' the hospitals as part of an integrated Trust. They have accepted that, although staff now tend to see the organisation as one Trust, the communities' loyalties are to their local hospitals. Feedback from local groups revealed that attempting to promote the Trust above the hospitals caused residents to see the Trust's foci as being managerial structures rather than clinical quality and policies rather than people. Since the Trust's role organisationally is to facilitate and ensure the provision of care, management decided the Trust as an "organisation" could afford to be relatively 'invisible', provided

the publics believed that their hospitals were providing high quality care. This strategy may come under strain however as the Trust pursues its current reconfiguration and delineates service provision between the two sites.

Performance Review

The Trust has a history of strong performance in annual performance reviews, receiving three stars in 2003, two stars in 2004 and three stars in 2005. In 2006 it attained a 'good' rating from the Healthcare Commission for both services and use of resources and was commended for its strong evidence of high quality performance for at least the previous two years.

Evidence of Commitment to the Coordination and Management of Clinical Work

The Trust's formal organisational structure provides a clear signal that the management of clinical work and its coordination throughout the Trust has always been central to the Trust's day to day and strategic operations. From the Trust's establishment, key members of the Trust (including the Organisational Development Director) had a keen interest in the development of integrated care pathways. With the CEO's support a Clinical Governance Support Unit was created to pursue this strategy. This unit is based within the Corporate Division as a department of the Medical Directors' Office but has teams located within the divisions. Its role is to advance clinical governance, promote continuous improvement in service delivery, and support and develop the work of the clinical networks. (The Medical Director's Office provides a number of functions, which includes clinical audit, integrated care pathways, research and development, clinical guidelines.) The CGSU's work was supported by a Trust-wide policy on the development, implementation and training for ICPs and included a six step programme for progressing ICP development. These teams' work was well coordinated and supported throughout the Trust with resources, team and governance structures, staff training programmes for those new to ICPs, complete with six-step manuals about how to develop and implement new pathways. These structures and teams for developing ICPs were already in place at the start of the Clinical Management Development project.

North Tees and Hartlepool NHS Trust

Overview of Services and Location

North Tees and Hartlepool NHS Trust (NTH) commenced operations in April 1999 following the merger of North Tees Health NHS Trust and Hartlepool and East Durham NHS Trust. Like CHFT, NTH provided 24-hour acute (general district hospital) services on two main sites, the University Hospital of North Tees in Stockton on Tees, Halifax (UHNT) and the University Hospital of Hartlepool (UHH) in Hartlepool. (Both hospitals were renamed in May 2001 after the Trust was awarded 'University Hospital' status by Newcastle University's Medical School). The Trust provides some outpatients services at a third site, the Peterlee Community Hospital, in Peterlee to the north of Hartlepool.

The two main sites lie 14.5 miles apart. There are no significant geographical features providing a natural divide between the two sites however the two town districts have somewhat different historical loyalties. Hartlepool residents are famous for drawing their identity from their seafaring history and the supposed 'lynching' of a monkey as a French spy during the Napoleonic Wars. Stocktonians draw their identity from the town's association with Robert Stephenson, the Stockton and Darlington railway, world's first steam hauled passenger train, and heavy manufacturing industry.

UHH is approximately one and a half miles north of Hartlepool town centre. In 2005 the Trust website described the hospital as serving 147,500 people living in Hartlepool and the southern part of East Durham and having 334 beds. (This separation of service areas contrasts with the CHFT website which has always given population figures for the Trust as a whole.) The hospital opened in 1966 and expanded over the years with the addition of various wings and services. The main building has been recently refurbished however many of its other buildings are rundown and unsuitable for housing patients. The local community however are proud of 'their' hospital which has long had a reputation for being innovative and forward thinking, being one of the few hospitals in the region to make early investments in day case surgery, open system MRI scanners and a Philips CT scanner.

UHNT is approximately two miles north of Stockton town centre. It first opened in 1966, also expanding in the provision of buildings and services since that time. It was/is a regional centre for breast screening. In 2005 the Trust website described it as serving 178,000 people in Stockton and 20,000 people in Sedgefield. It also has many buildings in need of refurbishment; the old maternity wing is currently being refurbished to serve as Trust headquarters.

Activity figures for the two sites listed on the website were, until very recently, years out of date. Up to and including July 2007 the lastest activity figures posted on the website showed that in 2000/2001:

- UHNT treated over 177,000 patients:
  - 96,518 patients in outpatient clinics
  - 40,920 patients in A&E
  - 25,497 emergency admissions
  - 14,329 elective admissions (9,020 patients as day case patients) and
  - 1,819 babies were born at the hospital.
- UHH treated over 163,000 patients:
  - 85,965 patients in outpatient clinics
  - 41,198 patients in A&E
  - 23,263 emergency admissions
  - 12,918 elective admissions (9,684 as day case patients) and
  - 1,604 babies were born at the hospital

Peterlee Community Hospital treated 8,245 people in its outpatient clinics.

These figures are presented here, in part, to show the relative sizes of the constituent hospitals. More important, particularly from an organisational analyst's perspective, is the impression conveyed by the obsolescence of these and other data on the website. In July 2007 the Orthopaedics web page referred to a service award made in 1998, the Surgery and Urology web page referred to the introduction of single sex wards in advance of the government directive for 2003, the gyneacology webpage announced Mo Mowlem's official opening of an extension to the outpatients' department in UHH in 2001, and so on through the service listings. The corporate information was likewise out

of date – in early July 2007 strategy documents for 2002-2003 were still available and the organisational chart showed senior staff as they had been in early 2005, including staff who had long since left the Trust. A corporate strategy for 2006-2009 was available elsewhere on the site. However the retention of obsolescent data and the absence of up to date information about how the Trust is structured and managed, conveyed an impression that the organisation had lost its way, preferring to look back to its 'glory days' rather than anticipating a hopeful future.

Organisational Governance

At the time of writing (August 2007), NTH had an unusual managerial structure. Like CHFT it is overseen by a Trust Board. Unlike CHFT, its key management team is the Trust Directors' Group (TDG) comprised of 22 people. These are the Executive Team (the CEO, Deputy CEO/Director of Nursing and Clinical Governance, Deputy CEO/Director for Acute Services, Director for Medicine, Director for Finance, Director for Human Relations and Operations, and Director for Information and Management Technology) and 16 clinical directors (despite having only six clinical divisions). The Executive team meets weekly to overview policy and performance, suggest responses to performance figures, and set the agenda for the Trust Directors' Group. The TDG meets monthly to take decisions on both clinical and financial matters on behalf of the Trust as a whole. The preponderance of medical staff on the TDG is intended to increase medical participation in decision making on difficult issues facing the Trust.

Each clinical division is managed by a clinical director (a doctor) who is expected to provide leadership within the directorate and a clinical manager whose role is to deliver the service. The clinical manager may be drawn from any of the clinical professions but is usually a nurse or an allied health professional. In divisions without departments, the clinical director and the clinical manager are the only managerial staff. In the divisions with departments, the managerial staff will also comprise departmental heads (who may be doctors or ward sisters depending on how the department is organised.) The 'extra' clinical directors do not have formal responsibility within each directorate; their role is to represent the views of the various specialties to the TDG and the views of the TDG to their specialist colleagues.

This structure was introduced mid 2005 after the appointment of a new CEO and is not the structure that governed the Trust's participation in the Clinical Management Development project. In August 2007 the most up to date representation of the Trust's governance structure (which was then still on the Trust's website) showed the CEO position vacant and named executive directors who had left the Trust in early 2005.

The governance structure in the Trust during the Clinical Management Development project comprised an Executive Team which oversaw corporate governance and which referred clinical matters to a Clinical Policy Board (CPB). The CPB was comprised of the Executive team and the heads of the clinical directorates. The CPB was characterised by mistrust and divided between two power bases. The Executive team (and the Chairman of the Board) were those of the previous Hartlepool Trust whilst the clinical directors were drawn solely from clinicians from the previous North Tees Trust. In the main, the Executive team adopted the same approach to management they had utilised prior to amalgamation and retained occupancy of their old offices in Hartlepool. This, together with the financial strength of the previous Hartlepool Trust (and the indebted state of the former North Tees Trust), led staff in North Tees to generally regard the amalgamation as a 'takeover' whilst staff in Hartlepool regarded the North Tees 'acquisition' as a financial millstone. The only visible strategy to address the sense of takeover grievance was the appointment of an executive director with responsibility for representing the North Tees site and for community development. This position only lasted six months; when the director resigned, the position was abolished.

Long term staff at Hartlepool suggested that the Hartlepool hospital had a 25 year tradition of very strong leadership, possibly to the point of being somewhat overly prescriptive. The Hartlepool CEO apparently fitted comfortably within this tradition until amalgamation. She was respected for running a 'tight ship' and having a very visible presence amongst staff. Several senior staff formerly from Hartlepool Trust commented over the period of the CMD project and in the course of this research, that the CEO's leadership style changed when the Trust amalgamated with North Tees Trust.

During the CMD project staff at various levels of seniority had described her style prior to amalgamation as including regular 'tours of the staff'. She was known to engage with staff, to ask unanticipated questions, and to inquire about processes and progress; this engagement provided an incentive for staff to demonstrate competency and initiative. After the amalgamation, however, the inspections dwindled on the Hartlepool site and never really started on the North Tees site. None who commented about this had an explanation for the change. There was some limited and half-hearted speculation that it might have been due to the perceived hostility emanating from the North Tees based staff; mostly however, staff seemed mystified by it. Hartlepool based staff, however, appeared to associate the decreasing visibility of the CEO with a sense of drift within the Trust.

Vision and Values

The 'vision' statement for the newly amalgamated Trust was "Two Good Hospitals Serving Two Local Communities". In conformity with this statement both sites continued to operate independently, providing the same services they had previously according to ten 'people first values'. This vision statement was presumably adopted in the hope that it would allay the fears and resentments associated with the amalgamation. It meant however that the North Tees site continued to operate largely as it had previously, inherited debt and repeated operating losses notwithstanding.

Opinions were divided within the Trust about the reasons for this 'non-interference' in the operations of the North Tees site. Some staff thought that the Executive team lost its nerve in the face of the trenchant hostility from North Tees staff. Others thought that it was a pragmatic interim step given the divisions within the Clinical Policy Board, staff resentments across the clinical work force, and the first Tees-wide service review (with a remit to produce recommendations for health service delivery options well beyond the Trust's geographic area). They attributed its continuance to the constraining effect of protracted, disputed and repeated service reviews which were widely believed by staff to have been initiated by local parliamentarians for short term political gain. (The Trust's future was studied in three major reviews of service in eight years – the Teesside, Darzi, and the Secretary of State reviews.)

The perceived political machinations associated with these reviews undermined their credibility amongst staff, creating unwillingness in the Trust at all levels to implement recommendations. This created a 'damned if you do, damned if you don't' scenario for the Trust Executive. With little internal support for the recommendations, when they discussed implementing the recommendations they were portrayed by some staff as foolish and 'weak' for not challenging the recommendations. On the other hand, other staff (and even, at times, the same staff) regarded the Executive as indecisive, naïve, even foolish when they indicated that they wanted to challenge 'politically based' findings. And all the while the underlying deficit, the operational problems at the North Tees site, and the internal tensions especially within the orthopaedics department remained unaddressed until the Royal College of Surgeons' 2004 critical review of the orthopaedics department.

Performance

Until this time, despite internal awareness of problems and conflict, the Trust had performed well in inspections. When the Trust formed in 1999, both sites had good reputations for the quality of their clinical care. These reputations carried over into the amalgamated Trust and for several years it garnered strong results from the Commission for Health Improvement and its successor, the Healthcare Commission, achieving three stars in 2003 and 2004. In 2005 however the Trust received only two stars, due partly to the criticisms by the Royal College of Surgeon's report on the orthopaedics department and partly by weak financial performance. In 2006 it attained a good rating for the quality of its care but a weak rating for its financial management. Until very recently both UHNT and UHH provided the same range of specialist emergency and elective care.

Evidence of Commitment to the Coordination and Management of Clinical Work

Staff report both 'ends' of the Trust had a strong history in innovatively seeking to improve the management of clinical work. The North Tees Trust had been one of the original pilot sites for the RMI and the Hartlepool Trust had been keen to learn the lessons and adopt new practices to improve care. In both predecessor Trusts in the 1990s, an alignment of RMI and willingness to try the then newly developing ICPs

resulted in the Trusts supporting early experiments in care planning, especially in the intensive care units. According to nurses involved in those early care planning efforts, however, the enthusiasm for the quality of care innovations was not matched with enthusiasm within departments for taking responsibility for budgets nor with overall organisational strategies for care improvement. The availability of 'pilot' money, in combination with this lack of enthusiasm, meant devolution of autonomy was not matched with a transfer of organisational accountability, for either systematic care improvement or fiscal responsibility. It also meant that pathways were being developed independently in various areas of the Trusts and without overall coherency.

This enthusiasm for innovation and new care practices, especially those that relied upon new IT developments, was severely damaged due to failures to achieve the outcomes in care improvement that were expected to follow. The failures were sourced in IT problems, specifically the poor technical competency of many IT systems, the lack of compatibility between clinical IT systems within the hospitals, the lack of compatibility between the GP systems and others, and the resultant difficulties in coordinating practice and providing continuity of care. Senior nurses in NTH, who were with the Trust(s) at that time, believe that the resulting distrust and cynicism about care planning and IT systems greatly impeded subsequent efforts to pursue more systematic approaches to care planning. Pockets of enthusiastic care planning persisted over the years but, prior to the Clinical Management Development project, these were not supported by the wider organisation, systematically supervised, or coordinated within or across divisions. The Trust's participation in the CMD project began to change this.

Chapter Seven

The Clinical Management Development Project

The CMD Project

The CMD project was a research-based, interactive and collaborative project which aimed to support the modernisation of the NHS in Yorkshire and Northeast England. Six local health economies were each represented at the first exploratory workshop by about ten staff drawn from primary, secondary and mental health services. The two health economies to which the study Trusts belong were well represented at this initial meeting.

The workshop agreed that the project would take three stages. The first two were research oriented. There would be an examination of professional subcultures within health economies and an examination of how care was actually being provided within the health economies for three clinical conditions of significance to all parties (fractured neck of femur, COPD and angina). (An examination of HES data to map local activity flows within each health economy was added subsequently and conducted concurrent with the cultural survey.) The third stage was developmental work aimed at improving the provision and management of care for these conditions through the establishment of integrated clinical pathways.

The workshop agreed that responsibilities within the project should be shared: the research would be the responsibility of the Centre for Clinical Management Development, with assistance from the partners as required, and the developmental activity would necessarily be the responsibility of the NHS partners but mediated in part through workshops facilitated by staff of the CCMD. These workshops would report and discuss the research results of each stage with a view to understanding the developmental implications for each organisation and health economy.

As the project progressed, further support for developmental activities within each health economy and component organisation emerged from the interaction of each organisation's development plans, the results of the research, and understandings and negotiations between the relevant NHS organisations. This support comprised working parties attended by various members of the project, internal organisational meetings attended by members of CCMD, internal organisational training days, and further

workshops as deemed appropriate within each health economy. As far as possible these developmental activities were incorporated into the usual Trust meetings. This was intended to both to 'normalise' efforts around the improvement of clinical work management as being part and parcel of Trusts' day to day work and to minimise the strain on staff who often were already feeling the burden of repeated, significant change and the pressure of having to meet stringent performance targets. Although six health economies initially agreed to participate, only four health economies actually commenced the project.

Early Meetings in the Study Trusts

The first official meetings between staff from CCMD and individual organisations within the health economies in 2002 were small. From the perspective of Centre for Clinical Management Development (CCMD) staff, the purpose of the meetings was to introduce the CCMD staff to each individual NHS organisation's management and vice versa, and for each to gain further understanding of the project and its possibilities in each location. From the NHS organisations' perspective however the initial meetings were more about the managers deciding whether they still wished to participate in the project given the multitudinous mandatory performance targets and pressure for continuous change with which they were burdened. Such conversations required considerable frankness about Trusts' financial position and existing resource allocations, understanding of activity patterns, organisational strategy, internal climate and power relationships within and between organisations, and the benefits the CMD project might bring in dealing with these.

Calderdale and Huddersfield NHS Foundation Trust (CHFT)

The initial meeting in CHFT was attended on the Trust's side by the executive team and two divisional directors. The Director for Organisational Development met the CCMD staff and escorted them to the Board Room to await the rest of the CHFT senior management. The CEO was perhaps the third person from CHFT to enter the room. She introduced herself as Diane (no role was given) and asked if she could pour some tea. Whilst she was doing so, the rest of the CHFT staff arrived. Everyone took their seats and the director for organisational development introduced the Director for CCMD, inviting him to make a presentation about the CMD project and its anticipated

benefit. Introductions were not made at this point; the director for CCMD simply started his presentation, various people asked questions, made suggestions, gave opinions, and challenged others' opinions. The conversation was friendly, at times joking, open, direct and honest. For at least 30-45 minutes it was not clear to CCMD staff who was the CEO. (The CEO had asked some questions, made some comments, but contributed much less than several other CHFT staff.) Her position as CEO was only revealed when the CHFT team became divided about whether the CMD project would merely replicate work already being done in the Trust or would provide an additional benefit worth the nominal investment of money. (The actual cost at that point was being borne by the Northern and Yorkshire Modernisation Board through top slicing of Trust budgets). At that point one of the CHFT team turned to her and asked her opinion as CEO. She stated that she was leaning towards continuing the Trusts' initial support for the project but wanted further information and time to think. She asked some questions about the details of the Trust's existing organisational development (OD) programme, and whether and how this programme and the new project could create synergy. She then turned the meeting back to other members of her team. At the end of the meeting she advised that she had found the whole discussion very stimulating and thought provoking; she would discuss it further with her executive team before making a final decision. A few days later she invited the director of CCMD to meet, learn more about the CHFT existing programme, and explain where he thought the new project added extra value. A month or so later the OD director advised CCMD that the Trust would participate, the CEO would actively support it, and the OD director would oversee the project to ensure that it meshed neatly into other projects and contributed towards the Trust's goals. However, if at any time, the CEO believed that the CMD project was having minimal effect or was distracting the Trust from its goals, she would withdraw her support and the Trust's participation.

The initial programme of work the OD director organised was primarily around the conducting of the staff cultural survey. There was some tension about this within the Trust as the CEO thought it might unnecessarily replicate a recently completed Trust staff survey. To ensure the survey generated 'added value' the OD director organised a series of workshops within the Trust around various aspects of culture, the Australian

experience of casemix, and various other topics. After about four months it was agreed that a structured programme of regular work would be more effective than ad hoc meetings. It was agreed that the director of CCMD would spend three days of every month in the health economy, meeting with staff, conducting workshops and providing advice to the various organisations involved. Some of these workshops involved staff from the PCTs along with staff from the acute Trust; others were solely for PCT staff.

The first major whole economy workshop, held to discus the results of the surveys and the existing pattern of clinical activity within the health economy, took place one year into the CMD project. It was attended by executive managers from CHFT, senior management and PEC members of the associated PCTs, plus various staff and other local health economy organisations whose attendance was considered important. At the time CHFT had been in existence for nearly two years; the PCTs however had not been in existence for a year and were staffed to a considerable extent by people who had previously been employed in the NHS Trust. The attendees were therefore people with significant decision-making power within their own organisations, who were meeting with their equivalents in the other Trusts, and who knew each other reasonably well.

A sense of anticipation pervaded the workshop and the atmosphere throughout the workshop was amiable. Conversation moved relatively quickly from 'sacred', abstracted talk about the desire to achieve patient centredness, effectiveness, efficiency and individual organisational priorities to acknowledgements that no one organisation currently had control over the rates of readmission to secondary care, nor could they in the present circumstances, and that this was creating ongoing problems for all of them. The rest of the workshop was characterised by 'backstage' conversation i.e. the conversations gave explicit recognition to the political dimensions of the matters being discussed. This included the likely responses of various groups within the health economy to possible future strategies. Concerns were raised about boundary management implications in attempting to promote increased collaborative working between the NHS Trust and the PCT and between the PCT and the GPs. As a result, it was agreed that a common governance structure/steering committee was needed for

the project and the Clinical Work Development Project Board was formed. The board, attended by senior members of all parties including CCMD, was led by the CHFT Divisional Director for Medicine and the Elderly (since retired). This project board met every two months for the duration of the CMD project.

North Tees and Hartlepool NHS Trust (NTH)

The initial meeting of the Trust management and CMD project staff from Durham University was a meeting of senior healthcare managers in the health economy. It was attended by the deputy CEO, medical director and assistant HR director for organisational development of NTH, the CEO for Easington Primary Care Trust, the acting CEO for the Hartlepool PCT, the acting CEO and Professional Executive Committee Director for the North Tees PCT and the four academic staff from Durham University. The meeting went extremely well with each participant providing a frank account of where they thought their organisations were, the problems each faced, and the priorities they were pursuing. Each agreed that they were pursuing individual solutions to systems-based problems and achieving only limited improvements from major initiatives. The limitations were attributed to the interdependent nature of healthcare, lack of control over the patterns of healthcare activity, problems of debt and formal leadership in two of the PCTs, and a history of suspicious and combative relations between the PCTs and NTH.

It transpired that this meeting was the first time that senior staff from the various Trusts had met to jointly discuss operational issues. Their previous joint meetings had been part of Service Level Agreement negotiations which had been characterised by fierce argument about changing the provision of care 'at the margins' and the financial implications of this. It also transpired that much of the argument arose from the fact that no organisation had firm activity data about the level of service being provided by NTH. This included the extent to which activity from various categories of patients, especially patients with long term conditions, accounted for all hospital activity. The NTH staff acknowledged with that they were providing what could be considered 'unnecessary' care from an acute care perspective, but argued that the hospital had to do this because of problems in primary care. All thought that it was probable that the number of

'revolving door' or 'frequent flyer' patients equated to about 8-9% of yearly hospital activity and that the amount of 'unnecessary' acute care provided was another 8-9% of activity.

The director of CMD suggested that a way forward would be to jointly analyse and discuss NTH's activity data to put some facts around the conjecture. CCMD undertook to do the analysis on the Trusts' behalf - it seemed critical for the CMD project and for the Centre for Clinical Management Development's obligations to its funder to establish an improved, cooperative climate between the parties. It also appeared that the then established pattern of care was, in part, an outcome of both the historical provision of care and the prevailing organisational and professional cultures within the health economy. The various parties met regularly every four-six weeks for eight months to discuss progressive findings from the analysis of the activity data, and to determine the next set of desired analyses. Meetings were always cordial, and often frank in nature, but attendance, which was initially consistent across the partners (including several attendances by relevant staff from local social services), became patchy over time.

The reasons for this were not clear; anecdotally and on reflection, it was perhaps an indication of the growing strains between the various organisations. Tensions were developing between the PCTs as they struggled to keep an integrated agenda. In private, each blamed the other for their problems. There was tension between the two PCTs which were struggling to fund desired projects and the third, which had a surfeit of cash but found it hard to attract both staff and general practitioners to provide healthcare. There were also growing tensions between the PCTs' leadership and the CCMD's leadership over appropriate styles of working and speaking.

The first major health economy-wide workshop (a three day event) to discuss the findings and implications of the culture survey and patterns of activity was held approximately one year into the project. It was a difficult meeting due in part to a power imbalance between the NHS attendees and the PCTs attendees. NTH was well represented by its senior management team including the CEO however the PCTs were each represented by a small number of middle managers. Further, the staff of the

PCTs and NTH had little experience of working together apart form the previously mentioned acrimonious SATT/SLA meetings. The workshop was also unsettling in that it was the first time most of the CCMD staff had met the NTH CEO. She had not been present at any of the activity workshops or other meetings; the newness of the situation hindered the previously relatively easy discussions that had developed between the staff of CCMD and NTH during the data analyses.

The atmosphere at the commencement of the survey based workshop was somewhat negative and defensive. This resulted from a combination of factors; each participating organisation contributed to these in some way. The contributions included:

- The relatively poor prior relationships between Trusts,
- The researchers' realisation that they had misinterpreted the extent to which 'spells' data (one of several ways of measuring inpatient activity) was then being used in the NHS and that much of the activity results to be presented needed to be revised,
- Disappointment amongst the NHS Trust's attendees at the poor representation by the PCTs,
- Vulnerability by PCT attendees who felt out numbered and 'out-gunned'.

Conversation within the workshop was dominated by NTH's interests which added to the PCT members' sense of being marginalised. The tension was magnified greatly when the NTH CEO offered to transfer £1m to the PCTs to kick-start a focused chronic disease management programme in primary care but the offer was not received as well as the CEO had hoped. The PCT staff were not at a sufficient level to act on the offer and they felt patronised by the manner in which the offer was made. Attempts to facilitate constructive dialogue around the offer through an impromptu role play initially produced very rational and defensive responses about ensuring 'PCT financial soundness', 'compliance to expenditure rules', 'proper administrative processes', and monitoring budget time frames. As the role play went on, the refusal/inability of the PCT staff to dilute their defensiveness increased the NTH CEO's and the CCMD director's frustration. Emotions became inflamed; the language and tone of speech became

belittling and aggressive. The role play ended with name calling and the CEO threatening to withdraw her offer.

Frantic work to hold things together during the second evening meant that the workshop atmosphere improved noticeably for the final morning. Unfortunately, late in the morning another middle ranking member from North Tees PCT joined the workshop. Lacking the extensive briefing of the survey results and activity patterns, and the (painfully) produced consensus about issues confronting the health economy, this staff member also became very defensive about PCTs' capacities and strategies. This staff member took issue with the CMD director's manner and the projects' methods, kicking the fracas off again. This time it was not possible to soothe tensions and the workshop ended on a sour note.

Several important consequences for the outcome of the project in the local health economy resulted from this. Of relevance to this thesis were North Tees PCT effective withdrawal from the project (although it did provide some support for the research into the organisation of care for COPD and angina) and secondly, and perhaps somewhat surprisingly , the NTH CEO, who previously had been lukewarm about the CMD project, became more supportive of its objectives. NTH then initiated several workshops between the Trust's senior management and CCMD to explore a much more prioritised and structured approach to the use of clinical pathways and a reworking of the Trust's model of clinical governance.

During the first of these subsequent workshops, the CEO could see both pros and cons for increased clinical management through the use of ICPS and was still somewhat undecided about whether to support the development of ICPs more vigorously. After discussion with her staff, she decided to put her weight behind the CMD project and a Trust-wide approach to ICPs. The establishment of a 'pathways steering committee' (PSC) was agreed to which the Director of CCMD, and senior members of PCTs and social services were to be invited. At the second workshop between CCMD and the CPB, however, the CEO took offence at something that was said by the director of

CCMD. It was never clear what caused the offence but further workshops planned for that year, whether for the Clinical Policy Board or for clinicians, did not eventuate.

Participation began to pick up in late 2003 and throughout 2004 due almost solely to the efforts of three NTH staff, the assistant director for organisational development, the pathways lead, and the medical director. Through their efforts and as a result of the DoH's push on chronic disease management, Dr Foster's raising the profile on activity data analysis, North Tees PCT involvement in activity analysis around the Evercare trials, the North Tees PCT began to re-engage with the CMD project. Within NTH, several key consultants in respiratory diseases and orthopaedics engaged with the project and workshops were held both within NTH and across the health economy. These followed-up the research results and agreed further work to design cross health economy pathways for the three clinical conditions for which the organisation of care was mapped. Design and implementation of four other orthopaedic ICPs within NTH was also agreed. The PSC also came into operation.

The operation of the PSC was somewhat problematic. Several NTH members were very concerned that the revitalisation of clinical work management, through the introduction of ICPs and their use for both clinical governance and performance management, did not fail. This anxiety was due to their belief that a history of failed implementation or abandonment of 'flagship' programmes in the Trust had already created clinical resistance and another failure would create a very difficult management problem. They therefore were keen to see progression and success and promoted an active role for the Trust in pursuing pathways development across the health economy. Several PCTs members, however, were resentful that the NHS Trust was leading on the pathwaying work as they believed that, with the Shifting the Balance of Care policy and the emerging emphasis upon management of long term conditions, the lead on this committee should have lain with them. Perhaps as a result, attendance at the PSC was patchy, the minutes were perfunctory, and meetings were often cancelled. The CCMD director attended the new pathway steering committee once then delegated responsibility for the CMD project in NTH to me.

Trusts Involvement Over The Course Of The Project

Once the results for the organisation of care were analysed, presented to the various health economies, and future directions were agreed, the responsibility for further workshops and effort lay with each health economy and participating Trust. In reality how the NHS Trusts approached the project was critical for their health economy's participation in the project as a whole and their commitment to invest in developmental work around pathways.

Table 7.1 Sponsored Workshops Held as Part of the Clinical Management Development Project, by Health Economy

	Health Economy				SHAs	Project-wide
	A	B	C	D		
2002	4	12	2	8	3	1
2003	1	18	1	2	2	
2004	0	10	0	6		1
Total	5	40	3	16	5	2

Health Economy B = Calderdale and Huddersfield health economy
Health Economy D = North Tees and Hartlepool health economy
Health Economies A&D = the two (unnamed) health economies which also commenced the CMD project

Table 7.1 shows two health economies were relatively poorly engaged the start. Although the early meetings with health economy A went well, by the end of the first year commitment was obviously waning. A variety of reasons were given for this however the full reasons for the lack of commitment in this health economy were never clear. The initial meetings in health economy C went well however the Trust underwent amalgamation early in the project and the new CEO believed the Trust's focus should lie elsewhere.

As discussed above, the North Tees and Hartlepool economy (Health Economy D) was reasonably engaged in the first year; these meetings were virtually all joint meetings between NTH, the PCTs and CCMD. However there were almost no sponsored workshops in 2003; participation was limited mostly to the research function which could, and did, proceed with little input from the management of any of the health economy Trusts. In contrast, the Calderdale and Huddersfield health economy (health economy B), led by the CWD board, was very actively engaged across the lifetime of the

project. The CWD board organised health economy wide workshops, workshops for the senior managers of each organisation, workshops for clinical governance staff within and across organisations, workshops for particular clinical specialities, particular professions and multidisciplinary workshops for all staff treating specified clinical conditions. It oversaw the coordination, attendance and resourcing of these, and also arranged various meetings with staff groups within and across the economy to work on the details on initiatives (although the numerical balance was largely in favour of CHFT).

Clinician Engagement

Both CHFT and NTH experienced problems ensuring that medical clinicians attended workshops to which they had been invited, including those specifically designed for them. When challenged, the clinicians often resorted to claiming moral and time priority for their professional-client relationships over organisational commitments. Staff in both CHFT and NTH worked assiduously to gain secondary care clinicians' support for workshop attendance, meeting one-on-one with practitioners, attempting to build reciprocity through provision of clinically relevant outcome data, identifying each player's needs and strategic priorities, attempting to build goodwill and trust, and making time to unguardedly consider the pros and cons of new clinical management techniques. Although these strategies were successful in both Trusts, the numbers of clinicians attending workshops and meetings was noticeably greater in CHFT. This was perhaps not surprising as a team of people were engaged in this in CHFT with strong support from the Executive and the CWD board. In NTH, the work fell primarily onto the pathways lead with some support from the medical director and the assistant director for organisational development.

The strategy of relying heavily on one person in NTH was somewhat self-defeating given the anxiety of PSC members that the project succeed. For much of the time the pathway lead's only support was a part time secretary, paid for over twelve months by a donation from a pharmaceutical company. She received weak authorisation and support from the PSC, the Clinical Policy Board to whom the PSC reported, and/or the Executive team when experiencing difficulties in obtaining clinical engagement. This was, in part, due to the belief of the then medical director, who headed the PSC, that an authoritative approach would be counterproductive; persuasion was a better approach.

Mostly this stance was shared by others, however, it was evident that persuasion was ineffective with several key medics. During the third year the ICP lead experienced family difficulties. The subsequent work slowed which created further strain in the relationship with the PCTs.

Later Developments

In the third year of the CMD project a workshop was organised between all parties of the CMD project (including those health economies not participating in the developmental stage) and the Healthcare Commission. This workshop's purpose was to explore how ICPs might be brought within the nexus of the Healthcare Commission's review process of the clinical governance function and was very well attended. Even in those health economies no longer participating in the CMD project, staff had grasped the possibilities that an ICP-based clinical management model had for improving the effectiveness of clinical and organisational facets of healthcare (Maxwell, Degeling, Kennedy, and Coyle 2005). They were also very concerned however that this way of managing work was at odds with the way that clinical governance was conceived by the former Commission for Healthcare Improvement and how therefore the Healthcare Commission would potentially measure and report performance. The workshop produced a remarkable unity amongst the health economies about the value of ICPs and a restructured clinical governance function centred on them. It also revealed however that, at that time, the Healthcare Commission staff did not understand what the Trusts' staff were saying to them. Though key staff in CHFT and NTH were frustrated by this, it did not sway them from their support for changing their approach to clinical work management. If anything, the arguments in favour of it put by members of health economies A & C, (despite their greatly reduced involvement in the CMD project) seemed to buoy their enthusiasm.

Calderdale and Huddersfield NHS Foundation Trust

Joint working between the CHFT and the PCTs on the development of intersectoral ICPs proceeded during the project's third year. This work focused on the three clinical conditions that were mapped during the second year of CMD project. Difficulties arose periodically as the Trusts' efforts to manage the various pressures upon them often placed strain upon their ability to work jointly within agreed timeframes. The emphasis

upon ICPs as a form of management of clinical work in CHFT nevertheless increased in prominence due to the effort devoted to an eighteen months Integrated Service Improvement Strategy (ISIS). This review began towards the end of the CMD project.

The ISIS was initially an internal service reconfiguration activity designed to jointly improve the financial and clinical effectiveness of clinical work within the Trust. It was prompted by three overlapping needs to i) attain the 18 week target for elective surgery ii) transfer services from acute care closer to patients' homes and iii) become competitive and remain financially viable under patient choice. Although based upon the three guiding principles of services, devolution and partnership, it was quickly realised that none of these goals could be achieved without a thorough review of patients' journey throughout the Trust and the wider health economy. This renewed attention within the health economy on ICPs, both with and across organisations, and has led to the development of numerous new ICPs and the review and revitalisation of previously existent pathways. The end result will eventually affect all clinical demand areas with CRH effectively becoming a women's and children's hospital and an elective surgery centre. Though it will retain its A&E department, all trauma related care will be relocated to HRI which will become a 'hot' care site with no elective surgery at all.)

The commitment to prioritise the management of clinical work by CHFT noted in the previous chapter is also being deepened in organisational forums and processes more distant to traditional spheres of clinical management. At the time that this thesis was being written up, the Trust was beginning to examine staffs' job descriptions and annual performance review criteria to reflect greater organisational recognition and accountability for the patient experience and the coordination and management of clinical work. It was also considering means for rewarding high performing 'teams' (though not necessarily financially). Thus there are plans to write participation in ICP processes into new clinicians' contracts, to ensure that job descriptions clearly indicate that all managerial staff (whether general management or clinical) are accountable for the outcomes of both populations of patients and organisational outcomes in addition to their usual professional accountabilities, and to think creatively about rewarding teams through high profile events within the Trust and the community.

This does not mean however that the Trust has fully implemented the ICP-based model for the management of clinical work which arose out of the CMD nor that progress has been without problems. At the beginning of 2006 CGSU staff felt that, with increasing devolvement of responsibility for ICPs to the divisions, practices within the divisions were no longer aligning well with strategic objectives. Furthermore the CGSU's strategic objectives and activities were not well evidenced within the Trust's business plan. They believed that the support for ICPs was not being evenly coordinated and was becoming inconsistent across the clinical divisions, with patchy engagement and utilisation of care pathways emerging. A key member of the CGSU therefore undertook a review of outcomes for CHFT as a result of the Clinical Work Development Project (CWDP), focusing on both the broader organisational outcomes, as well as outcomes at a clinical speciality level (Rudge 2006). As a result of this review the Trust has now adopted the 80/20 principle in relation to the use of integrated clinical pathways i.e. the Executive Management Board has supported ICPs use for about 80% of its clinical work (particularly its inpatient work); the other 20% of clinical work is regarded as being too low in volume for ICP use. This is much higher than the percentage recommended by the CMD project (three initial pathways, then pathwaying of the top ten HRGs, followed by pathwaying of 50-60% of clinical work, depending on the measures of activity used.)

When asked in July 2007 to provide an estimate of the resulting total number of pathways in operation in the Trust, the response was that this wasn't centralised information. To count ICPs in this way would a) turn them into another activity silo b) place the focus on a paper document that could be stacked on shelves and counted off and which, in turn, would c) misconstrue the nature of pathways away from a dynamic process of continual refinement of the patient journey and quality of care into a static, check box exercise. The OD director believed a better indication of the priority given to ICPs was the increasing importance being placed upon the reporting of activity for both clinical governance and performance management purposes along ICPs lines. This type of reporting was occurring within both the medical and surgery divisions (and to the Executive committee) for a selection of their pathways with the aim of extending the

approach to further clinical conditions as the processes and implications of undertaking performance management in this fashion were more understood and honed.

This 'failure to count' pathways and to provide detailed analysis of their outcomes can be viewed in several ways. It can be taken at face value for what it is portrayed to be namely, evidence of an ongoing but not yet completed attempt to entrench ICPS conceptually as mechanisms for instituting a dynamic process, or as a failure to consider quality improvement in structure, process and outcome terms (Donabedian 1980). Then again, it might be that CHFT staff were thinking along Donabedian lines and were seeing the early development of organisational reporting along ICPs lines as being in itself an appropriate managerial outcome. Once reporting clinical work in accordance with these precepts began to be more deeply established, the trust should then be in a position to report on clinical outcome improvements (or lack thereof).

North Tees and Hartlepool NHS Trust

As noted earlier the developmental work on a standardised approach to pathways in NTH began with the angina and COPD pathways and five orthopaedic pathways including fractured neck of femur. The two medical pathways were intersectoral pathways and required the involvement of the PCTs and others. Work on each of these seven pathways began well with strong interest and support across the treatment community in both primary and secondary care. However the work on each of them stumbled significantly over seemingly minor matters, particularly around documentation.

In the case of the angina and COPD pathways, and despite earlier problems in obtaining clinician support, the respiratory physicians in the acute Trust were highly motivated and enthusiastic about the work. The pathway work groups (multi-professional subgroups ranging across the health economy) quickly agreed that the pathways should adopt the approach of the cancer network and provide a hand held pathway for patients in which each health professional would record patient-professional interactions. Various concerns about who would 'own' the record, what other records should be kept by community nurses, GPs, and hospital staff, and how the care accorded patients would be governed were sorted relatively painlessly,

although with some effort. A real problem however emerged over what the patient held record should look like. There was strong disagreement over the size of the packs (pocket sized versus A4), the types of cover they should have (thick card or plastic), and how much information they should contain (a very detailed record of each patient's treatment regime and clinical status or just a summary).

These relatively simple matters drew more concern than the ICP coordinator expected and were not quickly resolved. Frustrated at the protracted nature of these discussions, the acute physicians decided that, as the specialist physicians, they would make the decision. Their subsequent announcement that a minimalist record would be adopted greatly angered the primary care and community professionals who believed that this was, at a minimum, an overstepping of authority by the acute Trust's staff.

A similar problem arose within the NTH in relation to the orthopaedic pathways. In this case the disputes again centred around how much detail the pathways should contain, how the theatre and anaesthetic records within the pathways should be highlighted, and whether one of these should be more prominently highlighted than the other. Each of these matters could, and should, have been settled relatively quickly. The Trust's medical records department had standard guidelines on these matters that were, in relation to the theatre and anaesthetic dispute, largely informed by legal requirements for such records. Regarding the matter of document length, common sense and the practices of Trusts elsewhere should have been sufficient guidelines however these were not heeded. The ICP lead, tasked with resolving these disputes, did not have the status or power to settle the disputes. She was not part of the orthopaedic department, she was a nurse, she was a similar grade to the nurse(s) who insisted on lengthy documentation formats, and she lacked organisational authority to intervene in disputes between medical departments and in disputes between medical departments and the medical records department. The then medical director intervened when she requested support however his persuasive style meant that recalcitrant parties were never made accountable for their refusal to cooperate. His successor in the role agreed with the concepts of ICPS but he also failed to challenge the doctors about the processes which

they were adopting (or rejecting). This result is that this pathway has rarely been used and has never been audited.

At the beginning of 2005, after repeated requests by the pathway lead, the PSC signed off on a new devolved structure supporting pathways and policies regarding their implementation. These gave responsibility for overseeing ICP implementation and review to PSC, prioritised pathway development according to the top HRGS (for both emergency and elective activity), placed the initiative for implementing these pathways with the divisions, and provided an approved documentation format for recording the pathway structure and data points. Each pathway was to be adopted as a pilot for three to six months, audited and reviewed. However the Pathway Steering Committee ceased to exist when the CPB was restructured and its role in overseeing pathways was not brought into the new TDG. The ICP lead was transferred into a review of nursing resources and a new position for implementing a new nursing management resourcing strategy and system. She was not replaced in her post as ICP lead (although she retained informal association with the role through people's association of pathways with her).

By September 2007, ICPs had been developed for the top ten HRGs however few were actually in use, those that were in use had not been audited (with the exception of the laparoscopic colesectomy pathway), and the ICP lead role had been withdrawn.

Discussion

The disputes in NTH about apparent trivialities in ICP development and operation masked more serious points of contention. Each of the disputes was fundamentally, though not overtly, about power and status – who got to write where in the record, how many pages did they need and in which order, and whose pages looked more important than others. These are matters which theoretically and practically should have been resolved quickly and convincingly. Similar disputes had arisen in CHFT and resolved through an emphasis upon piloting and widespread reportage and praise of successful outcomes in particular departments and divisions, which was intended to foster a desire by other departments and divisions to achieve similar results. That this did not happen

in NTH appears to be the consequence of clinical staff reacting to the perceived paralysis and indecision amongst senior management.

The literature discussion in Chapter Three noted that there has been little study of how the effectiveness of the executive 'team' relates to the effectiveness of clinical teams and vice versa. The discussions in this and the preceding chapter suggest that coherence in the senior management team is a necessary, if not sufficient, condition to a Trust achieving a consistent approach to clinical management. Without coherency within a team and throughout their decision making, senior managers (and their delegates) lack an authoritative conception of clinical work and its performance. They also lack the social authority to make the exercise of power visible, accountable, and efficient.

The first senior management structure in NTH was potentially unwieldy and unstable; it was well known to contain inbuilt division and it potentially signified a lack of either vision or will to make the Trust truly one organisation. The additional 'signals' given by the choice of vision statement, the lack of senior management presence, even the structure of the web page and its presentation of information, could all suggest, or reaffirm, to staff and others that the senior management team was unable or unwilling to take hard decisions. The history of NTH post amalgamation is an illustration of how, without social authority at the top of an organisation, a power vacuum can develop, destabilizing the organisation and undermining its ability to achieve goals and agreed policies. Although the literature suggests that destabilisation commonly takes the form of a struggle between professions to take the lead in setting the direction and operations of Trusts, in NTH it appears destabilisation occurred more through a break down of accountability and an associated unwillingness to take hierarchical responsibility. As a result, staff who were committed to improving clinical management lacked the organisational support and strength to prevail during difficulties. Even with the arrival of the new (now departed) CEO, there was a lack of organisational will to pursue changes in clinical management.

On the other hand, the CHFT amalgamation was characterised by initial actions, announcing in word and deed, that the Trust was to become one unified Trust in both management and practice. Since that time, the senior management have made considerable headway towards their vision of a Trust characterised by robust clinical management systems with significant clinical engagement. The transformation of institutionalised processes in this Trust has been, and is being, pursued with a high degree of coherency in thought and effort by senior management and their representatives. It is manifested at all levels by the realignment of organisational structures, repeated clarification and reiteration of organisational goals, and by regular monitoring of managerial and clinical processes, accountability mechanisms, and reward systems for their impact on the reform process. This congruency and consistency in visualising a goal, striving towards it, and monitoring progress towards it is enabling senior staff to learn from their efforts. It assists them to further disseminate their newly gained knowledge in ways which embed changed practices and structures into additional Trust arenas, producing yet greater penetration of supportive processes for new clinical management practices within the Trust's wider organisational practices.

Chapter Eight

Sub-Professional Stances on Reform Values

Introduction

Chapter Three outlined the importance of culture in both defining and enabling acceptable and unacceptable behaviours within any particular societal group. It also discussed tensions that may be at play within organisations when subsections of the organisation have entrenched cultural differences. This chapter reports the results of a survey of 987 survey participants' stances within the study Trusts and associated healthcare organisations in relation to various matters pertaining to clinical management. The survey was conducted in 2002 at the commencement of the Clinical Management Development Project; it therefore reveals the predispositions, values and beliefs of important healthcare professional groups prior to the project developmental work.

The participating staff were medical managers, medical clinicians, general managers, nurse managers, nurse clinicians, allied health managers and allied health clinicians in hospital Trusts; managers including PEC members, community nurse managers and clinicians, allied health managers and clinicians in primary care Trusts; and general practitioners, practice nurses and practice managers within general practice. They were asked for their opinions on many issues relating to the organisation, delivery and management of health work and the current reforms.

Results Summary

The results showed that the professional sub-groups across the whole of the Clinical Management Development Project maintained distinct views about the central aspects of the reform agenda. These differences in views held both across health economies and between primary and secondary care, with small local variations. That is, when a professional group in secondary care manifested a particular view about an aspect of the reform agenda, their colleagues in primary care tended to hold similar views. Likewise the views of each professional group in primary or secondary care in one local health economy were good approximations for the views of the same professional groups in another local health economy. The stances of the various professional groups (for the study as a whole) are summarised in Table 8.1.

Table 8.1 Summary of Professional Groups' Stances on Issues Relevant to Modernisation

Acute Trusts	MC	MM	GM	NM	NC	AHM	AHC
Accept the interconnections	-	+	+	+	+/-	+	-
Transparent accountability	-	+/-	+	+	+/-	+	-
Systematise clinical work	-	-	+/-	+/-	+/-	+/-	-
Multidisciplinary Teams	-	-	+/-	+	+	+	-
Primary care	LEAD	GM	NM	NC	GP	PN	PM
Accept the interconnections	+/-	+	+	+/-	-	+/-	-
Transparent accountability	+/-	+	+	+	-	-	+/-
Systematise clinical work	+/-	+	+	+	-	+/-	+/-
Multidisciplinary Teams	+/-	+/-	+	+	-	-	+/-

Key: MC= Medical Clinician, MM= Medical Manager, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, AHM= Allied health Manager, AHC= Allied Health Clinician., LC = Lead Clinician, GP = General Practitioner, PN = Practice Nurse, PM = Practice Manager
'-' = disagree, '+' = agree, '+/-' = equivocal

The Medical Professions

The table shows that despite the heterogeneity of doctors with the category 'medical clinicians' (surgeons and physicians in secondary care and GPs in primary care), doctors tended to oppose all aspects of the reform being sought whereas medical managers in secondary care and lead clinicians in primary care were generally equivocal about the reforms. This however tended to take different forms. (Lead GPs are practicing GPs who either sit on the managerial bodies of PCTs or who have a managerial responsibility for the introduction of more protocol driven approaches to care for particular conditions within their local primary care fraternity.)

At the start of the CMDP hospital medical mangers had accepted the interconnections between clinical and resource decisions, perhaps because this aspect of the agenda is the one that has been 'pushed' determinedly in secondary care for several decades. Lead clinicians however were ambivalent about the interconnections between resources and clinical decisions. This presumably was due in part to both the newness of PCTs and the lead GPs' role and to the then existing funding arrangements enforcing a practical separation of clinical and financial aspects of care. Until the advent of primary care Trusts (and with that, PCT- and practice– based commissioning), the majority of general practitioners, without experience of fundholding, had little or no incentive to take responsibility for the financial implications

of care they provide. The cost of pharmaceuticals, diagnostic interventions, and staff requirements elsewhere in the system were not their concern.

Both medical managers and lead clinicians were equivocal about the need for more transparent accountability, preferring to be accountable to themselves and their patients. This was perhaps not surprising given that they sit at the intersection of (frequently competing) collegial profession-based accountability and hierarchical organisational accountability systems. The tenets, traditions and etiquettes of medical professionalism and its legal power bases incline doctors' allegiance towards a system of accountability based upon Trust and relatively opaque peer review. Increasingly however the public, governments and NHS managers (as the delegated representatives of the state) require that medical professionalism is more rigorously overseen by the organisations in which doctors are employed. Because of their joint roles, doctors with managerial responsibilities could 'see both sides of the fence' however this was not a position that sat well with their more purely clinical colleagues.

Lead clinicians were equivocal about systematised approaches to healthcare provision and to sharing power across professions whereas medical managers in secondary care tended to object to these features of the modernisation agenda. The reasons for this were, and are, not immediately obvious. Lead clinicians often commented anecdotally on the tensions inherent in attempting to achieve the mooted benefits in managing populations in situations of minimal influence on other GPs, and poor staffing and constrained funding within PCTs. Hence these views may be derived from lead clinicians' wider responsibilities for populations of patients within the PCT and/or their legislated multidisciplinary power structures.

General Managers

General managers in both primary and secondary care tended to support all the reform directions although they were somewhat ambivalent about the use of multidisciplinary teams. The only difference between general managers in the two sectors was that the secondary care general managers tended to also be ambivalent about the

systematisation of clinical work (through the use of integrated care pathways, clinical guidelines etc).

The Nursing Professions

Nurse managers tended to support all the reform directions although, like general managers, secondary care nurse managers were somewhat ambivalent about the need to systematise clinical work. Anecdotal evidence suggested that although nursing managers often were committed to agreed best practice by all health professionals, especially in order to eliminate unjustified and unexplained variations in care, they were highly sceptical that doctors would support proposals for this.

Nurse clinicians were the only professional group whose views about the reform items were apparently influenced by their work setting. Nurse clinicians in primary care tended to generally support reforms whilst those in secondary care tended to be ambivalent. Practice nurses were ambivalent about accepting the resource implications of clinical decisions and more systematised approaches to care. They were disinclined to support increased transparency in accountability and the power sharing implications of teamwork; a finding perhaps understandable given the difficulty of power sharing with their employers (the GPs).

The Allied Health Professions

Allied health professions were included in the secondary care sample however their low (population) numbers meant we were unable to include them with any degree of statistical validity. Bearing this caveat in mind, the results for secondary care revealed that, despite the fact that these staff usually work more closely with nursing staff than medical staff, they tended to hold similar views to medical clinicians. This may reflect the high degree of specialisation of many allied health staff and the relative autonomy that this gives them in their work.

Professional Sub Cultures in More Detail

Disaggregation of each of the aspects of the modernisation agenda described above permitted a more in-depth understanding of each professional group's stance. These

more detailed stances of groups are reported in the following tables and discussion. The results for virtually all factors show a statistically significant difference of p<.001.

Stances on Interconnections between Clinical and Resource Dimensions of Care

Tables 8.2 & 8.3 (below) show that across both sectors of care only those professional groups with managerial responsibilities were prepared to recognise and accept that all clinical decisions are also financial decisions. General and medical managers in both sectors, especially in secondary care, appeared comfortable with this proposition. Nurse managers in secondary care however were close to being equivocal. Although secondary care clinicians tended to oppose the proposition, in primary care nurse clinicians and GPs were effectively equivocal whilst practice nurses and practice managers were inclined to deny and reject it.

Table 8.2 PCT and General Practice Conceptions of the Interconnections between Clinical and Resource Dimensions of Care

	PCT				General Practice			
	LC	GM	NM	NC	GP	PN	PM	Sig.
Recognise interconnections between clinical and the resource dimensions	.55	.55	.31	-.08	-.04	-.35	-.44	.000
Taking account of resource issues enhances autonomy	-.17	-.03	.59	.36	-.29	.26	*	.000

Key: LC = Lead Clinician, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, GP = General Practitioner, PN = Practice Nurse, PM = Practice Manager
Shaded cells indicate that the stance reported in this cell is in accordance with the desired direction of reform.
* Practice managers did not answer this question

Table 8.3 Hospital Staffs' Perceptions of the Interconnections between Clinical and Resource Dimensions of Care

	MC	MM	GM	NM	NC	AHM	AHC	Sig.
Recognise interconnections between clinical and the resource dimensions	-.21	.89	.68	.12	-.65	.14	-.40	.000
Taking account of resource issues enhances autonomy	-.42	-.15	.07	.18	.22	.07	-.33	.000

Key: MC= Medical Clinician, MM= Medical Manager, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, AHM= Allied health Manager, AHC= Allied Health Clinician.
Shaded cells indicate that the stance reported in this cell is in accordance with the desired direction of reform.

Within PCTs and to a lesser extent general practices, nursing staff were inclined to believe that taking account of resource issues enhances autonomy, perhaps because

many of these staff worked in relatively autonomous teams. However this was not an opinion shared by the rest of primary care providers nor is it an opinion that is held broadly in secondary care. Again, only nursing staff in secondary care could be positively said to hold this view, though only weakly.

Stances on Accountability

Table 8.4 (overleaf) shows that there was a significant split in primary care between PCT employed staff and staff employed within general practices. With only a few exceptions, staff within PCTs were in favour of all propositions relating to increasing transparent accountability in the provision of clinical work. All staff rated the need for more effective information systems issues as being a higher priority than concerns about clinical autonomy, a position consistent with their support for more organisationally transparent accountability. Likewise all professional groups tended to support the proposition that care providers should be accountable to both their patients and the general public for care provided. However only nurse clinicians tended to support personalised opaque accountability with any degree of firmness; lead clinicians, though supportive of this form of accountability, were close to being indifferent about it. The only proposition to which lead clinicians could be fairly said to be opposed was the suggestion that the existing clinical accountability systems may be inadequate.

Table 8.4 Primary Care Stances on Accountability

	PCT				General Practice			
	LC	GM	NM	NC	GP	PN	PM	Sig.
Shortcomings in clinical accountability	-.25	.38	.13	.05	-.31	.22	.23	.000
The importance of information systems relative to clinical autonomy issues	.29	.60	.17	.01	-.43	-.62	-.12	.000
Organisationally transparent accountability	.05	.28	.31	.23	-.55	.07	.98	.000
Personalised opaque accountability	.08	-.75	-.26	.37	.41	.46	.03	.000
Public and patient accountability	.12	.30	.53	.25	-.61	-.31	-.81	.000

Key: LC = Lead Clinician, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, GP = General Practitioner, PN = Practice Nurse, PM = Practice Manager
Shaded cells indicate that the stance reported in this cell is in accordance with the desired direction of reform

In contrast, staff in general practice tended to oppose all propositions relating to increased transparent accountability. None of the professional groups within general practice believed that the need for information should outweigh the need to protect clinical autonomy nor did they support being accountable to patients or the general public. Rather they preferred a closed, opaque system of accountability in which they were only accountable to themselves and their peers. The only group in general practice strongly in favour of organisationally transparent accountability were the practice managers. Despite this, practice managers tended to disagree with the proposition that shortcomings existed within the current system of clinical accountability. This suggests perhaps that practice managers, whilst believing that peer based accountability systems were adequate at a purely clinical level, perceived them to be inadequate at an organisational level.

Table 8.5 Secondary Care Stances on Accountability

	MC	MM	GM	NM	NC	AHM	AHC	Sig.
Shortcomings in clinical accountability	-.42	-.14	.56	.17	.07	-.02	-.33	.000
The importance of information systems relative to clinical autonomy issues	-.04	.62	.70	-.12	-.23	.41	-.33	.000
Organisationally transparent accountability	-.46	-.16	.26	.20	.18	.28	-.09	.000
Personalised opaque accountability	.04	-.01	-.69	-.22	.27	-.35	-.09	.000
Public and patient accountability	.08	.24	.10	.15	.11	-.01	-.22	.314

Key: MC= Medical Clinician, MM= Medical Manager, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, AHM= Allied health Manager, AHC= Allied Health Clinician
Shaded cells indicate that the stance reported in this cell is in accordance with the desired direction of reform.

Staff in secondary care Trusts tended to be supportive of the propositions relating to the need for increased transparency of care. The two professional groups for whom this statement was not generally true were medical clinicians and allied health clinicians. General managers in particular were supportive of the propositions in favour of increased transparency; overall, allied health managers were also supportive being clearly supportive on three of the five propositions and indifferent on two.

Nurse managers were also supportive of these propositions with the exception that, in common with nurse clinicians and medical clinicians, they tended to rank clinical

autonomy issues as more important than information system issues. Perhaps surprisingly, nurse clinicians tended to be in favour of opaque peer and profession-based accountability systems whereas medical and allied health clinicians tended to be equivocal about this. Medical and allied health clinicians were also generally in agreement that clinical accountability systems were functioning appropriately but varied between themselves about the relative importance of information system issues and organisational needs for transparent autonomy. They also tended to differ on the importance of being accountable to patients and the public – medical clinicians were generally supportive of this proposition whereas allied health clinicians were not.

Stances on Systematising Clinical Work

Table 8.6 Primary Care Stances on Aspects of the Systematising Clinical Work

	PCT				General Practice			
	Lead	GM	NM	NC	GP	PN	PM	Sig.
Increase service integration across acute and primary divide	-.19	.24	.71	.44	-.38	.39	.41	.000
Systematisation of clinical work	.28	.46	.46	.12	-.56	.03	-.18	.000
Using care pathways enhances autonomy	.25	-.04	.15	.29	-.31	.46	**	.000
Institutional shortcomings as cause of clinical practice variation	.03	.48	.51	.33	-.71	.21	.61	.000
Shortcomings in education & failure to keep up to date as cause of practice variation	-.38	-.19	.06	.34	-.12	.66	.31	.000
Self referenced and generated knowledge as a basis for setting clinical standards	.06	-.60	-.65	-.20	.47	.15	-.10	.000
Formal evidence as basis for setting clinical standards	-.27	-.07	.14	.27	-.41	-.06	-.75	.000

Key: LC = Lead Clinician, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, GP = General Practitioner,
PN = Practice Nurse, PM = Practice Manager
Shaded cells indicate that the stance reported in this cell is in accordance with the desired direction of reform
The item 'Shortcomings in education & failure to keep up to date as cause of practice variation' was not shaded as this item, though included within this bank of questions, does not relate specifically to the systematisation of clinical work
** Practice managers did not answer this question

Table 8.6 shows that general practitioners were consistently opposed to any proposition supporting increased systematisation of clinical work, a position at odds with most other primary care staff. PCT nurse managers and nurse clinicians were most supportive of propositions promoting greater systematisation in the management and performance of clinical work. These two groups tended to give strong support to calls for increased service integration across the primary/acute divide, considered institutional shortcomings to be an important cause of variation in clinical practice, and opposed self-generated knowledge as a basis for determining acceptable clinical

standards. General mangers of PCTs could also be considered to be weakly supportive of increased systematisation of clinical work - they were not effectively opposed to any of these propositions and were only indifferent to two of them.

Lead clinicians, practice nurses and practice managers could perhaps be summarised as being ambivalent about increased systematisation of clinical work. Each group supported some propositions and rejected others; however the three groups were not in general agreement with each other about which propositions were acceptable and which were not. Thus lead clinicians and practice nurses supported using integrated care pathways for increased systematisation of clinical work, and practice managers did not. Lead clinicians tended to oppose increased service integration across primary and acute care, practice nurses and practice managers tended towards support for it. Lead clinicians were equivocal about self referenced and generated knowledge as a basis for setting clinical standards, practice nurses supported it and practice managers opposed it.

Table 8.7 Secondary Care Stances on Systematising Clinical Work

	MC	MM	GM	NM	NC	AHM	AHC	Sig.
Increase service integration across acute and primary divide	-.63	-.56	-.42	-.04	.30	-.09	-.06	.000
Systematisation of clinical work	-.45	.21	.21	.21	-.28	.47	.00	.000
Using care pathways enhances autonomy	-.18	-.46	-.25	-.02	.12	.21	-.07	.036
Institutional shortcomings as cause of clinical practice variation	-.63	-.46	.47	.34	-.03	.38	-.15	.000
Shortcomings in education& failure to keep up to date as cause of practice variation	-.34	-.86	-.03	.09	.16	-.16	-.05	.000
Self referenced and generated knowledge as a basis for setting clinical standards	.45	.03	-.39	.14	.07	.00	.23	.000
Formal evidence as basis for setting clinical standards	-.07	-.08	-.04	.42	.28	.41	.17	.003

Key: MC= Medical Clinician, MM= Medical Manager, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, AHM= Allied health Manager, AHC= Allied Health Clinician
Shaded cells indicate that the stance reported in this cell is in accordance with the desired direction of reform
* The item 'Shortcomings in education & failure to keep up to date as cause of practice variation' was not shaded as this item, though included within this bank of questions, does not relate specifically to the systematisation of clinical work.

Propositions comprising elements of increased systematisation of clinical work were not well supported by any professional group in secondary care nor was there significant agreement about the form that systematised clinical work should take. The most supportive group were the allied health managers who tended to agree with four of the seven positions: these were the general statement that clinical work should be more systematised and the more specific statements that using care pathways enhances clinicians' autonomy, institutional shortcomings (whether in monitoring practice and care processes, establishing robust protocols or effective accountability mechanisms) are a cause of clinical practice variation, and that formal evidence should be the basis for setting clinical standards.

Surprisingly, given their common managerial positions, general managers and nurse managers jointly agreed with the allied health managers on only two of these propositions. These were the general statement in favour of increased systematisation and the suggestion that institutional shortcomings are a cause of clinical practice variation. General managers tended to oppose using self referenced and generated knowledge as a basis for setting clinical standards but, oddly, were equivalent about using formal knowledge as an alternative basis for setting clinical standards. Nurse managers held exactly the opposite position on these two propositions. Nurse clinicians gave general support to three propositions but they were alone in thinking this should include greater service integration across acute and primary divide.

Medical managers and allied health clinicians each supported just one of the propositions relating to the systematisation of clinical work. Medical managers appeared to support the concept as a generality but did not assent to any specific proposition. This perhaps suggests that they had accepted the rhetoric of clinical systematisation but, given the opposition of medical clinicians to all propositions concerned with clinical work systematisation, found themselves with no acceptable means to express this.

Stances on Multidisciplinary Team-Based Approaches to Care

Within primary care two professional groups were very supportive of multidisciplinary team-based approaches to the provision of care – these were PCT nurse managers and nurse clinicians. Table 8.8 shows that both groups believed team-based approaches to the provision of care were the most appropriate basis for undertaking effective management of clinical work and that this arrangement improved clinical autonomy. They also tended to be strong in their opposition to a medical ascendancy model of clinical management. Somewhat surprisingly, they were joined in this by lead clinicians and (more understandably) PCT general managers. Despite their stance against medical ascendancy in clinical management however, lead clinicians tended *not* to support team-based models of clinical management and did not believe these models offered greater autonomy to clinicians. The reasons for this are not clear.

Table 8.8 Primary Care Staff's Stances on Aspects of the Multidisciplinary Teams

	PCT				General Practice			
	LC	GM	NM	NC	GP	PN	PM	Sig.
Autonomy effects of team-based approaches to clinical management	-.19	-.12	.32	.33	-.48	.32	**	.000
Team-based approaches to clinical unit management	-.11	.28	.37	.27	-.42	-.19	.16	.000
Medical ascendancy models of clinical unit management	-.24	-.97	-.45	-.20	.48	.39	.49	.000
Hierarchical, financially driven clinical unit management	.10	.17	-.36	-.25	-.25	-.07	.12	.008

Key: LC = Lead Clinician, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, GP = General Practitioner, PN = Practice Nurse, PM = Practice Manager
Shaded cells indicate that the stance reported in this cell is in accordance with the desired direction of reform.
* The item 'Hierarchical, financially driven clinical unit management' was not shaded as it is not clear that the reforms seek either to foster or to undermine this form of management. It may be that teams are compatible with this type of management as well as others – at the very least it is a form of management which provides greater emphasis on the financial implications of care provision.
** Practice managers did not answer this question

Multidisciplinary team-based approaches to care were not the preferred method of working and managing within general practices. All professions were inclined to agree with the general practitioners' stance that care should not be team-based and that medical ascendancy is the most appropriate model for effective clinical management. The only exceptions to this were practice nurses' agreement with the statement positing beneficial autonomy effects in team-based approaches to clinical management and practice managers' relatively weak support for team-based approaches. It was

apparent that both these groups believed clinical management and clinical teams were best managed by medical practitioners. Neither of these stances was surprising given that both practice nurses and practice managers are employees of general practitioners.

The professions' stances on multidisciplinary team-based approaches to care provision in hospitals were similar to the stances in PCTs. Nurse managers supported all propositions. General managers were generally supportive but again questioned the proposition that team-based approaches to care enhanced clinical autonomy. Nurse clinicians appeared to support medically-led team-based approaches whilst doctors opposed any resemblance of multidisciplinary team-based approaches to clinical management. Secondary care medical managers however joined their more purely clinical colleagues in their opposition to multidisciplinary teams. Allied health managers were generally supportive of multidisciplinary team-based care but were equivocal about their impact on clinical autonomy. The allied health clinicians, in contrast, did tend to believe such teams would enhance clinical autonomy but seemed to prefer such teams to be led by medical clinicians.

Table 8.9 Secondary Care Stances on Aspects of the Multidisciplinary Teams

	MC	MM	GM	NM	NC	AHM	AHC	Sig.
Autonomy effects of team-based approaches to clinical work management	-.31	-.74	-.10	.41	.35	-.02	.22	.000
Team-based approaches to clinical unit management	-.28	-.23	.04	.16	.12	.15	-.11	.026
Medical ascendancy models of clinical unit management	.42	.22	-.64	-.22	.11	-.15	.27	.000
Hierarchical, financially driven clinical unit management	.02	-.01	.42	.17	.13	.13	-.16	.047

Key: MC= Medical Clinician, MM= Medical Manager, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, AHM= Allied health Manager, AHC= Allied Health Clinician
Shaded cells indicate that the stance reported in this cell is in accordance with the desired direction of reform.
* The item 'Hierarchical, financially driven clinical unit management' was not shaded as it is not clear that the reforms seek either to foster or to undermine this form of management. It may be that teams are compatible with this type of management as well as others – at the very least it is a form of management which provides greater emphasis on the financial implications of care provision.
•Key: MC= Medical Clinician, MM= Medical Manager, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, AHM= Allied health Manager, AHC= Allied Health Clinician, LC = Lead Clinician, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, GP = General Practitioner, PN = Practice Nurse, PM = Practice Manager

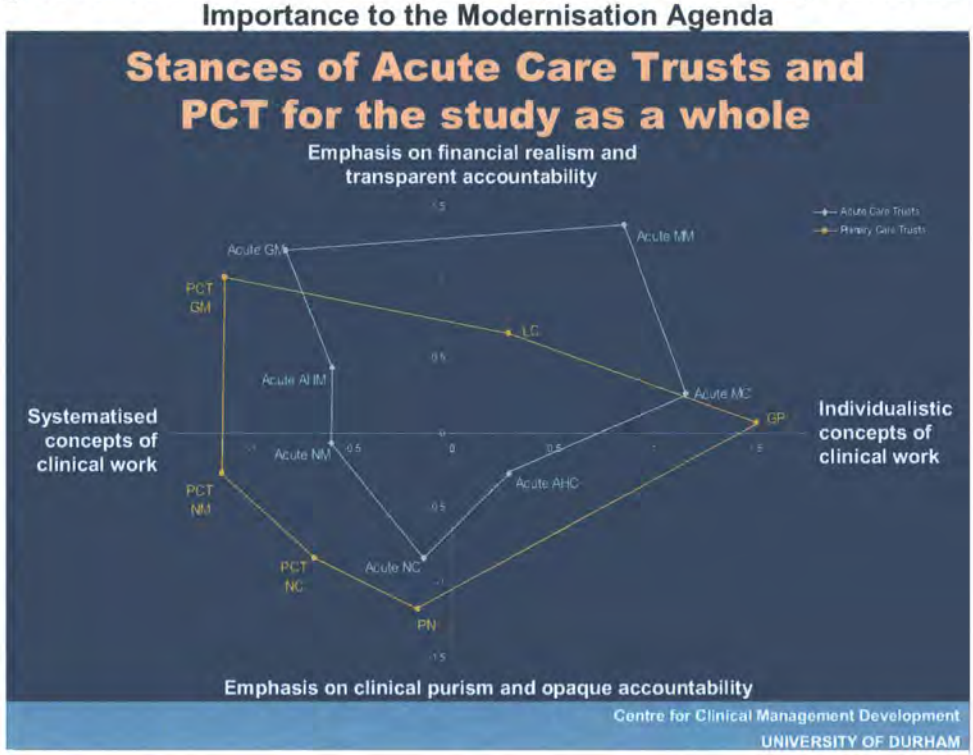
Graphical Depiction of Results

Overall

Statistical analysis revealed that the differences between the professional subgroups on aspects of the modernisation reform agenda occurred on six dimensions, two of which explained 84% of the variances between all respondents across the Acute Trusts, PCTs and General Practices. These two dimensions were:

- Individualised vs. systematised concepts of clinical work performance (50%) and
- Financial realism with transparent accountability vs. clinical purism with opaque accountability (34%).

Figure 8.1 Stances of Professional Groups across the Study on Issues of Importance to the Modernisation Agenda



Key: MC= Medical Clinician, MM= Medical Manager, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, AHM= Allied health Manager, AHC= Allied Health Clinician, LC = Lead Clinician, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, GP = General Practitioner, PN = Practice Nurse, PM = Practice Manager
Scores on axes were generated through the discriminant analysis of factors derived from respondents' Likert scores

These stances are summarised in Figure 8.1 which provides a visual depiction of the stances of each professional group in relation to each other. The stances of secondary care staff are depicted by the blue line; those of primary care staff by the yellow. The

figure shows several consistencies in relationships within professions and across sectors.

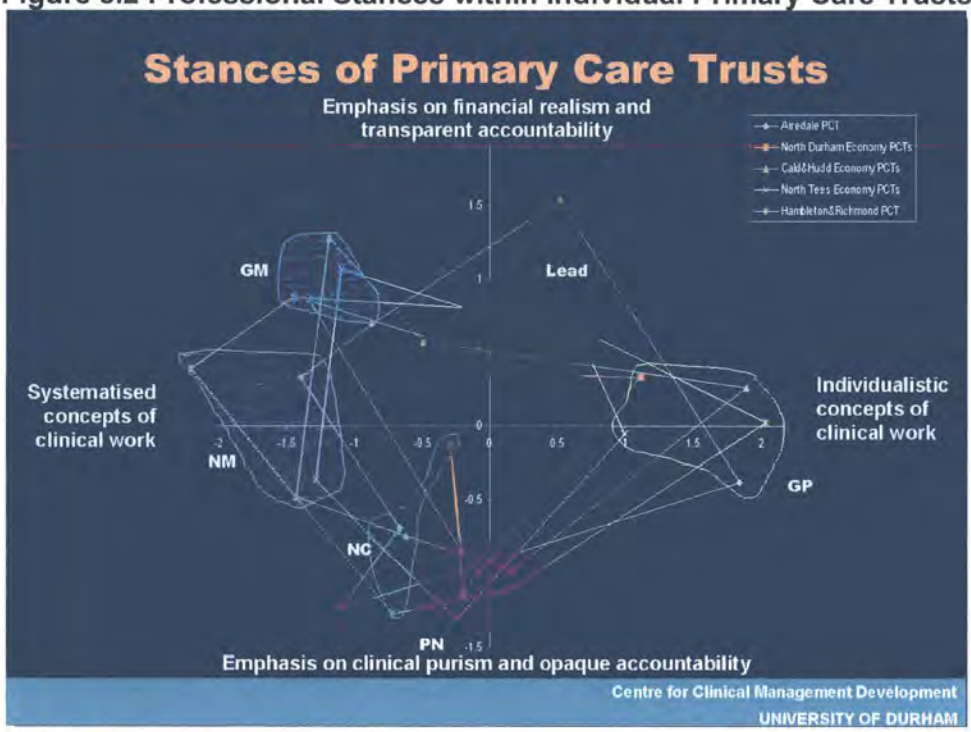
Regardless of the sector in which they worked, medical staff tended toward more individualised conceptions of clinical work whereas nursing staff held more collectivist conceptions. General managers were similar to nursing staff in holding conceptions of clinical work which were more grounded in a systems approach to clinical work. However medical managers (and to a lesser extent medical clinicians) were more accepting of the financial implications of clinical work than the nursing professions. Figure 8.1 also demonstrates that clinical managers (across all professions and both sectors) held more systematised conceptions of clinical work than did the individual clinicians. Even though, at times, the differences between managers and clinicians must produce significant tensions, these differences were primarily differences of magnitude rather than of nature.

(This is not true for allied health staff. Preliminary statistical investigations suggested that this may be a partial reflection of the heterogeneity within the allied health 'tribe'. In truth, allied health is not a tribe at all but a convenience grouping of very diverse professionals just as different from each other as doctors are from nurses, with the caveat that allied health staff tend to have a relatively high degree of autonomy. However allied health managers probably view clinical work more collectively for the same reason that medical and nurse managers do – they are responsible for patients on a population basis, even if in small numbers and not a patient-by-patient basis.)

The figure also shows greater distance in the stances of professions within primary care relative to secondary care. GPs and PCT general managers and nurse managers held strong, almost mirror opposite conceptions of the nature of clinical work. All non-medical primary care staff, even the practice nurses who tended to support medical dominance, held qualitatively different positions on the nature of clinical work and the reform program to the GPs. (Practice managers have been excluded from this diagram as they did not answer the survey questions about their understanding of clinical autonomy and accountability.) The lead clinicians' 'middle position' between these

groups appears to have made them the only professional group (by virtue of both their status and moderate views) capable of juggling or spanning the disparate stances of the primary care professions. However this may in fact be a tenuous suggestion. Though their differences from ordinary GPs were primarily differences of degree, the magnitude of the differences was such that, should they have actively pursued a boundary spanning role, these differences could quickly become, or be seen to become, differences of quality.

Figure 8.2 Professional Stances within Individual Primary Care Trusts



Key: LC = Lead Clinician, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, GP = General Practitioner, PN = Practice Nurse, PM = Practice Manager
Scores on axes were generated through the discriminant analysis of factors derived from respondents' Likert scores

The prospect of this occurring was suggested by Figure 8.2. This shows the distribution of professionals' stances by one standard deviation from each mean across the study PCTs. Some lead clinicians' responses place them in the systemised, collectivist, financially aware and organisationally transparent quadrant. If lead clinicians of this persuasion tried to coexist with those general practitioners who fell into the individualistic, clinically pure and opaque accountability quadrant, tensions would likely to result. Practices nurses may have provided some support for these lead clinicians in terms of greater systematisation but it appeared their support would not be forthcoming if they suspected systematisation would become a means for increasing organisational

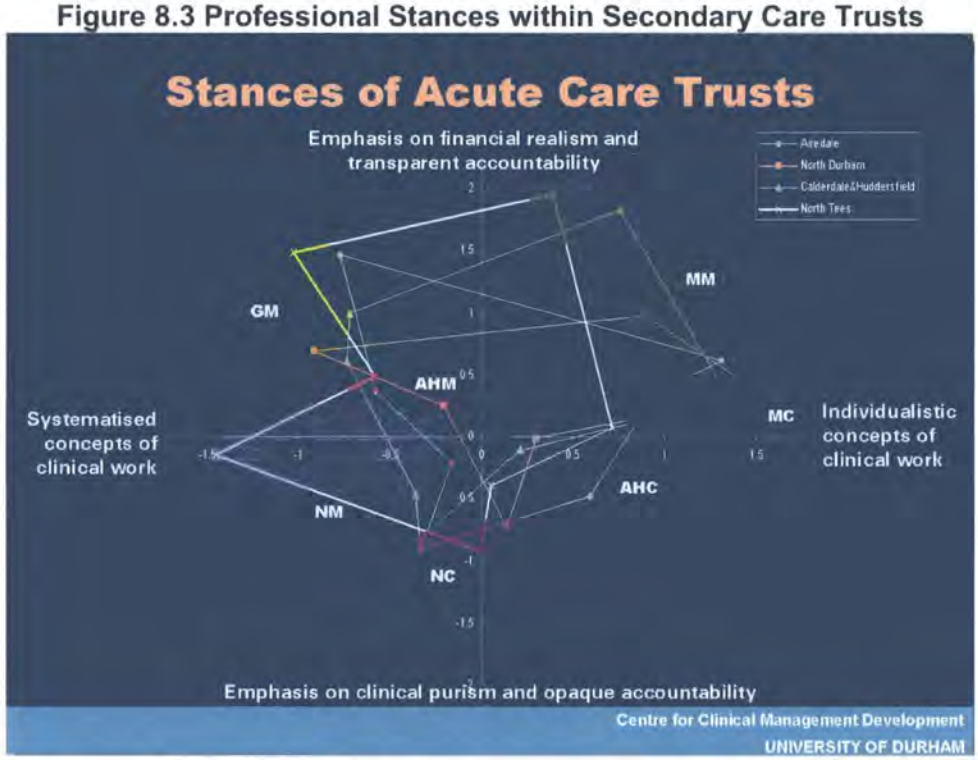
accountability rather than patient centredness. The figure suggested that lead clinicians of the more collectivist persuasion were at risk of being out of favour with all groups, considered not sufficiently supportive of reform by the other PCT managers and not sufficiently sympathetic and representative by their general practitioner colleagues. This, in fact, was exactly how many lead clinicians' represented their power during discussions in the developmental phase. Few suggested that they could easily or consistently expect to be willingly heard by their fellow GPs. Rather, they all expressed difficulties and a need to work very hard at maintaining the confidence of all their colleagues; they were very careful to pick an choose policies and strategies that might bring them into conflict with others and would not 'squander' the remaining credibility they had with other GPs on matters they did not regard as essential to healthcare improvement.

The figure also suggested that most professional groups in primary care were not as cohesive as earlier discussion may have suggested. Of the professional groups within primary care, only 67% of general managers and nursing clinicians (equivalent to one standard deviation from the mean) lay within one quadrant. The relative consistency within these groups is perhaps not surprising; PCTs were relatively immature and their general managers, all of whom were appointed under similar conditions with similar job descriptions, formed a relatively recent cohort. PCT nurses on the other hand, tended to be 'old hands'. They were people with a clear sense of mission who have performed the same role through many reorganisations of primary care and formal responsibilities(Peckham and Exworthy 2003). What *was* clear was that in all PCTs, a wide disparity existed between the views of staff in the key primary care groups (nursing and medical, managerial and clinician).

Compared with primary care, Figure 8.3 shows a greater internal cohesion within most secondary care professional groups at one standard deviation from the mean (67% of these professional populations.) At this level, there was no qualitative disparity between the majority of medical managers and medical clinicians who tended to favour individualistic conceptions of care and to weakly (in the case of clinicians) or more strongly (in the case of medical mangers) support organisationally responsible

approaches to care, including increased accountability for both the clinical and financial outcomes of their work General managers and the bulk of allied health managers held qualitatively similar views to each other, supporting more collectivised approaches to care with organisational responsibility. Unsurprisingly though general managers were more supportive of both these than the allied health managers. Nursing managers showed a relatively strong degree of support for coordinated, collectivised organisation and provision of care (they did not accept that patient care should be conceptualised on individualised bases) however they divided amongst themselves about whether they should adopt reforms that carried greater organisational responsibility. Within nursing, the most populous of all professional groups, there was tight agreement between the majority staff that patient needs should be prioritised above organisational needs; there were some (small) differences amongst the nurses about whether a collectivised or individualised approach to care was best. Allied health clinicians were virtually alone in their support for what is effectively the status quo – individualised approaches to care without organisational accountability for its outcomes.

Figure 8.3 Professional Stances within Secondary Care Trusts



Key: MC= Medical Clinician, MM= Medical Manager, GM= General Manager, NM= Nurse Manager, NC= Nurse Clinician, AHM= Allied health Manager, AHC= Allied Health Clinician
Scores on axes were generated through the discriminant analysis of factors derived from respondents' Likert scores

Figure 8.3 also shows that the professional groups' stances in the study Trusts were consistent with those of professional groups in other Trusts; small differences did exist between the groups' stances in each Trust but these were not statistical significant.

In summary, the data showed that the views of each professional group tended to be consistent across settings. There was greater consistency between each profession's culture across the health economy than with other professional groups within their own organisation or with government policy. This was true regardless of whether the issue was the conception of care (as an individual, even idiosyncratic, activity versus a collective, systematised practice) or the governance of care (whether chiefly a private activity undertaken by professionals and their peers or a more public activity within the healthcare organisations and/or the wider community).

Discussion

The analytical technique used in this chapter concentrates on the differences between groups. Work on areas of agreement between the various professions (or tribes), suggests that they tend to agree on what should *not* happen rather than what should (Bryman, Gillingwater, and McGuinness 1996; Hudson 2001). NHS culture (or at least culture within and across the study Trusts) at the start of the Clinical Management Development project was, and perhaps is in part, a culture based around enclaves and lack of consensus, even conflict.

The graphs of professions' stances within and across Trusts and health economies reflect the tenor of much of the literature concerned with reform in general and multidisciplinary teamwork in particular (see Chapter Three). A quick review of relevant academic databases (or even just a list of contributors to an issue of the Journal of Interprofessional Care) attests to the mutual concern of the non-medical professions (principally but not solely in primary care) to understand and improve teams, power sharing, leadership, interprofessional training and working, resource sharing mechanisms etc. Doctors are notable for their relative absence in these literatures.

This absence is perhaps not surprising given the current structure of the health service. Under current arrangements, doctors have a high degree of autonomy or 'clinical freedom' to self-describe, self-define, and self-evaluate their work (Degeling, Hunter, and Dowdeswell 2001; Harrison 1999) and have, to a large extent, successfully protected their clinical territory and freedoms against threats arising from the professionalisation of nursing, the proliferation of therapy professions, and the advance of managerialism (Peckham and Exworthy 2003). GPs have retained a relatively independent status vis-à-vis other doctors within the NHS, although this has potentially lessened with the devolution of the GMS contracts to PCTs. Further, as 'self-employed businessmen' albeit in a monopsonistic market, GPs employ considerable numbers of primary care staff, principally practice nurses, practice managers and receptionists A range of other health professionals are contracted in or co-located on site depending on local circumstances e.g. community nurses, smoking cessation consultants, dieticians, and physiotherapists. Thus GPs are not just de facto members of a primary healthcare team but its employer and/or leader, thus relegating other health professionals to a subordinate position.

The persistence of these structures arises in part from the legislative power imbalance in the doctors' favour (Kappeli 1995). Under legislative authority, doctors have power to restrict entry into their profession and to self-discipline themselves via the GMC. Although nurses and allied health professionals also have this power, their governing bodies lack the political influence of the GMC. Further, nurses and allied health professions have traditionally been subordinate to medical authority. Doctors often perceive this traditional authority and power as granting them a basis for disputing managers' right and/or efficacy to make decisions that affect the provision of care (Davies and Harrison 2003; Edwards, Marshall, McLellan, and Abbasi 2003) and for justifying their dislike of teams. It also provides them with a basis for resisting the 'territorial' conflicts arising from the increasing specialisation and professionalisation of healthcare work, for example, between medicine and nurse practitioners (Dean 2002; Neale 1999). The traditional separation of responsibilities such that doctors 'cure' while nurses 'care' (Baumann, Deber, Silverman, and Mallette 1998) and the culture of respect for the medical profession by the general public and other professions

(especially nursing and its acceptance of medically led teams and unit management, demonstrated in this chapter's results) has so far also assisted doctors in maintaining opposition to the modernisation reforms.

This apparently impregnable position however is weakening due to several factors, including adverse publicity and the desire of the public to prevent another Harold Shipman or Bristol Royal Infirmary. The generalist nature of GPs' work means that much of their work can be delegated to nurse practitioners without loss of quality (Hopkins, Solomon, and Abelson 1996; Horrocks, Anderson, and Salisbury 2002; Kinnersley, Anderson, Parry, Clement, Archard, Turton, Stainthorpe, Fraser, Butler, and Rogers 2000; Spitzer, Sackett, Sibley, Roberts, Gent, Kergin, and al 1974). PCT managers, as holders of the GMS and PMS contracts, now have the right (if, perhaps presently, not the will) to prescribe contractual obligations upon GPs that will alter the skill-mix and authority structures within primary care (Exworthy, Berney, and Powell 2002). A similar vulnerability exists notionally for doctors within secondary care for, although they are self-regulating professionals, they are also employees of the state and could theoretically be compelled to act as such. Further erosion of individualised expressions of medical power arises from efforts, both intra- and extra-professional, to substitute epidemiological and experimental evidence in clinical decision making for personalised and case-based evidence for example via the evidence-based practice movement and the National Institute for Clinical Excellence respectively.

Even should doctors accept these change imperatives and begin to act accordingly, by themselves these changes will be insufficient to permit successful reorganisation of the way clinical work is coordinated and managed, and to ensure implementation of the wider NHS Plan. For if medicine accepts less power in the performance and management of clinical work within organisations in order to adopt more multidisciplinary approaches to care, other professions will need to increase their responsibility in participating in, and leading, multidisciplinary teams. The results reported here suggest that within nursing, and to a lesser extent amongst general managers, in 2002 there was still a relatively strong preference amongst other health professions for doctors to lead in multidisciplinary teams and clinical units. Further, the

professional cultures in this study appeared to be influenced by an apparent lack of coherent conceptual thought about the core elements of clinical work and how these should be managed to produce treated patients.

The various professions differed in the aspects of the reform agenda that they accepted or rejected, perhaps for reasons that have been logical and/or traditionally supportable. It may be argued that at least each reform has some support somewhere in each organisation but this misses the key point that the reform themes do not operate in isolation from each other. Although individually identifiable, they are interdependent facets of clinical production. For instance, without mechanisms for making the components of care and their use transparent, it is impossible to realistically trace the financial and resource considerations of delivered care. The effort in implementing accountability systems for clinical work performance will be less than profitable if the information produced is not used to monitor, review and improve the organisation and conduct of care. Conducting reviews of individual aspects of care without placing these elements within the context of an overall plan or pathway of care does nothing to alleviate the acknowledged systemic problems in care delivery. Finally, a refusal to work and manage care in interdisciplinary teams results in an inability to evaluate and alter the effectiveness of the entirety of care.

Finding ways to bridge the key discontinuities and areas of disagreement between the professional subcultures of these NHS organisations, and their conceptions of professional and clinical work, must be crucial to successfully reconfiguring the management and performance of clinical work. Clinical managers, who straddle both the clinical and organisational domains of care provision, should be critical to this endeavour. However as demonstrated in this chapter and noted elsewhere (Degeling 2000), medical managers, in particular, hold predominantly individualistic conceptions of clinical work which preclude them from focusing on work as collaborative practice. This limits their (and others') discussions of health reform to a rhetorical debate; the contributions of other professions to health outcomes in these circumstances become ancillary to the debate. Degeling and others (Degeling et al. 2004) suggest that building discursive and communicative skills and practical legitimacy amongst clinician managers will help them find ways to mediate the contradictions and discontinuities

within and across professions, in the process building new ways of thinking and doing. However this will require determined effort and coherent support from senior management committed to the transformation of how clinical work is done and held accountable.

Chapter Nine

Staff Perspectives on Performance Improvement

Introduction and Overview

This chapter reports a thematic analysis of the open-ended survey questions about how, at the commencement of the Clinical Management Development Project, staff viewed clinical work performance, its improvement, and how clinical and organisational management could be better undertaken. The questions were deliberately wide and rather vague in order to avoid pre-specifying how respondents should structure their thinking and/or prioritise their comments. The three questions were headed by the words "What would you change?" and asked respondents, in the space provided for answering, to:

- "List changes in funding, organising and/or managing which you believe will significantly improve your clinical performance".
- "List changes in funding, organising and/or managing which you believe will significantly improve your experience of work".
- "Specify any changes you believe need to be made in the focus, funding and/or management of acute Trusts to improve the efficiency and effectiveness of your local health economy/community".

These three questions together were thought to provide an indication of how Trust staff viewed the functioning of their organisation, care provision within it, and ways to improve these. The responses as a totality were firstly analysed by theme, then grouped according to respondents' sub-professions, and reported by Trust.

The open-ended questions about various aspects of performance improvement followed after the close-ended Likert style questions of the cultural survey. It is not surprising therefore that the overwhelming majority of these responses were unelaborated lists or short, often terse, statements (although some comments were more prose-like and detailed). This limited the richness of many responses and, at times, posed difficulties for interpreting what was intended by the respondent.

Respondents were given individual identifying numbers in order to protect their anonymity (indicated by subscripts). This was designed to prevent the tenor and frequency of comments from especially disenchanted staff or enthusiastic staff from colouring the overall results. Responses were then counted according to the member

of staff for whom this aspect of organisation and clinical work performance was a concern. For example, a staff member concerned about a lack of resources may have listed up to eight or nine types of resources ranging from clinical staff to support services to beds etc but will have been counted only once. Counting in this way indicates the prevalence of concerns within and across staff groups but does not indicate the breadth of those concerns which, at times, was extensive.

The tables provide counts and percentages of staff from each professional subgroup participating in the survey commenting on each theme. Although seemingly large numbers of various sub-professions commented on a particular theme, support amongst staff as a whole for any particular improvement suggestion was often very low. This was because more staff did *not* comment than did. At times the low numbers and percentages of staff group members completing these questions raised concerns about the extent to which the responses were representative of the subgroup as a whole. The low response rate also potentially indicated some organisational disengagement. For instance, in NTH nursing clinicians' responses were remarkably infrequent compared to other staff groupings with as few as 5% (1/18) of nurse clinician respondents answering these questions.

The results showed that the similarity of stances within professions and the differences between professions discussed in the previous chapter were also present in respondents' suggestions for service and work life improvement. *Medical clinicians* within the two Trusts by and large focused on the need to improve the internal organisation of work and resource availability. The *medical managers* agreed but were less critical of management. They were keen to introduce changes that would allow them to better balance the differing responsibilities of their positions and to have a stronger information base for decision-making about clinical priorities, service design and contractual commitments. *General managers* were the professional subgroup most distinguishable between Trusts. In CHFT they could be characterised as having clear organisational goals, an inclusive approach to management, and agreement about how to do things differently. In contrast, general managers in NTH, though concerned to improve effective team and joint working within both the organisation and within the

health economy, seemed to lack ideas for doing so and tended to blame shift on to clinicians, external politics, and previous reorganisations of care. *Nurse managers* took a more personal approach to improvement suggestions, focusing on issues of time pressure, personal doubts about their (and others') management capability, especially in the management of teams. The *nurse clinicians* were mostly concerned with personal aspects of working life especially pay and working conditions (time pressures again featured prominently) and having greater access to training opportunities. They appeared to be very unhappy with their employment. *Allied health managers* were concerned about how care was organised internally and across each health economy. They were also concerned about the interconnections between resource availability, the organisation of care, and working conditions. *Allied health clinicians* tended to portray broadly similar views to their managers with additional concerns for increased training opportunities and the operation of multidisciplinary teams.

Support for more patient centred approaches to service improvement was relatively weak in both Trusts. There were indications that part explanations for the lack of progress in implementing ICPs lay in the sometimes seemingly paradoxical stances and differing organisational power and status of staff groups. Individual organisational factors were more prominent in the improvement oriented survey questions than in the more cultural/reform values sections. For example, staff in NTH at the start of the CMD project appeared somewhat more willing to adopt genuinely patient focused improvements than staff in CHT and NTH staff's stated values were more in line with CMD objectives than CHFT staff's values. However general managers in CHFT were more willing to acknowledge their own weaknesses and empower other groups, especially the medical profession, to work collaboratively in effecting change. CHFT staff were also somewhat distinguishable from NTH staff in the more positive tenor of most staff sub-groups' responses.

A. Staff Ideas for Improving Their Clinical Performance

Response categories for this question were arranged to flow from external influences to internal influences and from more immediately clinically relevant answers to less

immediately clinical relevant answers. The response categories identified from the data were as follows:

- Decreased political interference via service reconfigurations and activity targets,
- Improved organisation of clinical work **between** heath care organisations,
- Improved organisation of clinical work **within** the Trust including the provision/non-provision of services, use of integrated clinical teams, team based incentives, improved clarity in roles and responsibilities between clinical staff and between clinical and non-clinical staff, and increased opportunities for specialist clinical practitioners within the Trust,
- Increased access to information both in the type of data available (i.e. patient and clinical performance information) and better technology for accessing such data (e.g. electronic patient records),
- Improved education through more training, CPD opportunities, and library access,
- Resolution of non-clinical issues perceived to be relevant to the employment and performance of existing clinical staff. This was a very mixed category. It included amongst other things:
    - Recognising the contribution staff were making to the Trust including extra unpaid work (staff weren't necessarily looking for monetary reward, simple "thank you's" often appeared to be considered enough),
    - Addressing patterns of overwork and taking paperwork home to do at nights and on weekends,
    - Providing more promotional opportunities,
    - Removing inequalities in pay and power,
    - Better appraisal systems, and
    - More action taken on completed appraisals.
- Better organisational management. This took a variety of forms:
    - Clear organisational goals and objectives,
    - Better integration between the managerial and clinical domains of organisational life,

        - More strategic thinking (including allowing clinicians time to participate in organisational strategic thinking or to develop their own); and
        - Willingness for senior management to trust the clinical staff to perform professionally and to be innovative in meeting goals and targets.
    - Increased resources whether money, staff numbers, equipment or time. This response also included calls for greater freedom to use the resources available without burdensome approval structures (though most commonly the emphasis was upon volume of available resources).
    - Better facilities (e.g. accommodation for patients).

The categorisation of responses is, to some extent, subjective and may be debated. For example, clinical coding may be considered an administrative/managerial task, clinical work that needs increased recognition and reward, or a grey area in which roles and responsibilities between clinical staff and between clinical and non-clinical staff need to clarified. Each categorisation implies a different conception of the nature of clinical work; my categorisation of responses may therefore ignore ambiguities, create over-simplifications, and/or mislead the reader about staffs' capacity to appreciate the interdependencies and complexities within and between identified issues. Respondents often were aware of issue interdependency as the following quote indicates, "Staffing levels need to be addressed in order to improve training on new equipment but there is no point in installing new equipment to greatly improve service to patients if the old values, resources etc are reinstated". Comments such as this were classified according to the main themes within them; I recognise however that doing so overlooked the respondent's system awareness which some authors e.g. Deming (Deming 1986) and Seddon (Seddon 2003) would regard as extremely unfortunate.

Staff often appeared to conflate two or more different concepts, for example, it was apparent that both clinical and managerial staff often regarded clinical audit, research, and training as essentially the same thing e.g. "time for audit/research/CME". Perhaps for some staff, these activities are all means of improving their clinical practice and, in

that sense, interchangeable. These were however disaggregated and counted within the categories listed above.

A1. Improving Clinical Performance - North Tees and Hartlepool NHS Trust

The results for NTH are reported in Table 9.1 over the page. The two most common responses were more effective internal organisation of clinical work (35.8% of respondents) and increased resources (34.9%). Although these were common themes across all subgroups, the frequency of comments about these matters amongst medical clinicians pushed them to the forefront of improvement suggestions. Further, the number of medical clinicians completing this question and their higher than average number of comments meant that the views of doctors tended to dominate the responses to this part of the survey. Nurse managers were also in reasonable agreement about the importance of these two items however they were equally concerned about more effective organisational management. These two items were followed in frequency by a cluster that comprised more effective organisational management (21.7%), increased training, CPD opportunities, library access (19.6%) and access to clinical information and information systems (18.5%).

The professional groups that had most to say about how the Trust could improve the functioning of the health economy were allied health managers (3.7 comments on average per person), medical clinicians (3.5) and nurse managers (2.3). (As only three nurses commented on this question, their average, 2.6, is somewhat misleading).

Medical Clinicians (14/24)

As noted above, medical clinicians largely accounted for the first place ranking given to improvement of the internal organisation clinical work within the Trust as a means for improving individual clinicians' work performance with 100% of doctors completing this question mentioning this theme. The third most prevalent improvement suggestion by doctors was more effective organisational management. The number and tenor of comments around the need for improvements in these two areas conveyed an impression that staff believed the Trust was impeded by poor organisation of clinical work and services within the organisation. Doctors suggested this, together with poor

relationships between clinicians and managers, ineffective wider organisation and a lack of information, led to even basic care tasks being problematic at times.

Many doctors' responses about resources and internal organisation of care were crammed with details for example, "More supporting staff - I currently have to spend too much time on mundane clerical work, chasing results, filing carrying notes etc. Much better IT. Move ward nursing times - ward rounds are much less efficient than in the system - I waste time looking for patients/charts/etc. More beds. The 100% + bed occupancy that seems to be norm is inefficient as patients have to placed in 'only available bed'. Closer links with social works - on the ward. Even better (faster) radiology and lab services etc"[32].

Overall the comments suggested that doctors and others in NTH were not so much concerned with wanting more resources for themselves as desiring a better internal organisation of clinical work with more support resources to achieve it.

Medical Managers (4/6)

Medical managers' responses were similarly wide ranging, though for these and other staff (for example nurse mangers and allied health staff) clinical performance improvement was more a matter of making better use of the resources the Trust already had together with appropriate access to clinical information to guide and inform service design and delivery. For example, "Influencing referral patients from primary care. Delivering more clinical work to extended scope practitioners. Provide an effective IT system to capture clinical data, including coding. These will ensure that clinicians' time is used to maximum effect, seeing the right patient with shortest walk and working in teams"[39]. Some of the changes desired by the medical managers potentially would be highly controversial amongst medical staff, for instance the extension of extended scope practitioners, a desire for public league tables of doctors' outcomes[40], better evidence of "clinical competence for all health staff (qualified and nonqualified)"[43] and, perhaps less controversially, "reward and recognition of excellent performances to team rather than individual i.e. further investment in services"[41].

Table 9.1 NTH Respondents' Suggestions For Clinical Performance Improvement

	MC	MM	GM	NM	NC	AHM	AHC	Total (x)	
Numbers of respondents in each subgroup completing this question as a percentage of the subgroup that completed the survey as a whole	n= 14/24 (58.3%)	n=4/6 (66.6%)	n= 5/14 (35.7%)	n= 12/17 (70.5%)	n= 3/18 (16.6%)	n= 6/10 (60.0%)	n= 14/16 (87.5%)	n= 58/92 (63.0)	
	Number of Professionals Commenting in Each Professional Subgroup								% of All Respondents Remarking on Each Issue (x/92)
External influences	0	0	0	1	0	2	0	3	3.3%
Improved organisation of clinical work **between heath care organisations**	2	1	1	0	0	6	1	11	12.0%
Improved organisation of clinical work **internal** to the Trust	14	4	3	6	1	1	4	33	35.9%
Access to clinical information and information systems	8	1	0	3	0	2	3	17	18.5%
Increased training, CPD opportunities, library access	3	2	1	4	2	2	4	18	19.6%
Staff conditions and remuneration	3	1	1	2	2	0	2	11	12.0%
More effective organisational management	5	0	2	6	0	3	4	20	21.7%
Increased resources (whether £s, staff numbers, equipment)	14	1	0	6	2	4	5	32	34.8%
Better accommodation facilities	0	0	0	0	1	1	0	2	2.2%
Total Comments	49	10	8	28	8	21	23	147	
Average number of comments per responding staff in subgroup	3.5	2.5	1.6	2.3	2.6	3.7	1.64		

General Managers (5/14)

Surprisingly few general managers answered this question. No responding general manager appeared concerned about the overall level of resources. Instead they regarded the reorganisation of internal work as being most likely to contribute to improved clinical performance. Most comments were relatively terse listing points of action to be implemented across a range of clinically related concerns. Three made comments that were effectively about reigning in the power of consultants through a variety of mechanisms including "All decision making should be by a cross section of integrated clinicians managers and outside interested bodies who are informed by the most recent accepted and best practice"[51].

Nurse Managers (12/17)

It appeared that nurse managers, more than any other staff grouping, regarded clinical performance as relating to virtually all aspects of organisational life. They were particularly concerned about reciprocity of understanding between management staff and clinical staff, "Better training for clinicians to fully understand managerial aspects and implications of funding issues"[67], "a role in the balance of power to a more multi professional dimension"[60], "a management style which allows freedom of choice and professional autonomy"[59] and "co-ordinate clinicians to understand pressures with specialities other than their own"[70].

Nurse Clinicians (3/18)

Very few nurses answered this question. Those that did tended to see improvement as occurring through primarily more training opportunities and resources and sorting out anomalies in working conditions between acute staff based in-house and those based in the community, "Significant funding to allow staff time off for extra studying. Reorganisation of contracts i.e. Whitley and Trust - staff morale very low at present due to unequal contracts and conditions. Because of Trust contracts new employees are going to other hospitals, therefore there is a lack of staff in all areas of maternity"[18].

Allied Health Managers (6/10)

Allied Health Managers also took a wide view of requirements for improved clinical organisation however they were particularly concerned about relationships with external bodies, the availability of resources, particularly time (which they felt could be achieved either through more staff or the reorganisation of clinical work), and the role of the allied health profession within the organisational structure: "Sharing of best practice across sites and also with different Trusts"[79] and "Organising higher profile - equal influence/decision making as doctors and nurses: having a directorate structure. Seat on Trust Board for AHPs"[85].

Allied Health Clinicians (14/16)

Allied health clinicians were keen for more resources, better training, and improvements to both the organisation of clinical work and organisational management. These were often seen as inter-related issues, "Staffing levels need to be addressed in order to improve training on new equipment. An adequate service can then be provided at all times - not dependant on two members of staff only. There is no point in installing new equipment to greatly improve service to patients if the old values, resources etc are reinstated. Technological advances should be just that - not limited by out of date working practices and cost cutting exercises."[103]

Some of the most striking comments about ineffective organisation of clinical work were about their difficulties in working in 'integrated' teams, "Unfortunately we are managed by 3 separate organisations NHS Trust/PCT/Social Services. Consequently each manager/team leader often have (sic) separate agendas. I am employed by NHS Trust but the manager that takes most initiative in team leading is employed by Social Services. This gives me less autonomy than I would like to be able to change my own team"[93]. Despite these problems, allied health staff, more than any other staff group, still tended to regard integrated teams as a key way forward. The above respondent also said "I work as part of an integrated care team - greatest strength is that each member of staff works/communicates well"[93] whilst another said, "Partnership working and team working in the true sense would make significant changes in the clinical performance"[101].

Summary

The overriding impression gained from reading these comments was that the need to attend to the organisation and management of clinical work within the Trust was a common theme amongst NTH staff. However each staff group tended to emphasise different aspects of this, with some groups, especially the medical managers, favouring changes that could be controversial. It evoked the possibility that, rather than favouring a conservative approach to clinical and organisational management as the discussion in Chapters Six and Seven suggested, at least some medical managers would have preferred a more adventurous and inclusive approach to management. The responses from the other staff groups suggest that they have supported such innovative changes.

A2. Improving Clinical Performance - Calderdale and Huddersfield NHS Foundation Trust

In Overview

Table 9.2 overleaf shows that CHFT staff's suggestions for how their individual and collective clinical performance may be improved ranged across most improvement themes. It indicates that much higher percentages of staff within subgroups and CHFT as a whole made suggestions for how clinical performance may be improved than in NTH. It also shows that the numbers of suggestions made by individuals was more consistent across the professional groups than was the case amongst NTH staff.

The three sources of clinical performance improvements most frequently mentioned were increased resources, improved internal organisation of clinical work, and increased education and training opportunities. Although it was primarily nurses and allied health clinicians that desired increased training opportunities, after accounting for the different numbers of staff in the various subgroups there were relatively few distinctions in support between the sub-groups for most clinical improvement themes. One of these distinctions concerned the desire for more resources, especially time to create space for service planning. Whilst virtually all subgroups within the Trust desired increased resources, the general managers did not believe this would provide the answer. For general managers, clinical performance would be improved firstly and foremostly by them (that is, the general managers) lifting their own game.

Table 9.2 CHFT Respondents' Suggestions For Clinical Performance Improvement

	MC	MM	GM	NM	NC	AHM	AHC	Total (x)	
Numbers of respondents in each subgroup completing this question as a percentage of the subgroup that completed the survey as a whole	n= 25/35 (71.4%)	n=7/9 (77.8%)	n= 10/16 (62.5%)	n= 11/23 (47.8%)	n= 31/39 (79.5%)	n= 17/21 (81.0%)	n= 17/19 (89.5%	n= 118/162 (72.8%)	
	Number of Professionals Commenting in Each Professional Subgroup								% of All Respondent Remarking on Each Issue (x/162)
External influences	1	0	1	1	0	1	1	5	3.1%
Improved organisation of clinical work **between heath care organisations**	4	3	1	0	1	2	0	11	6.8%
Improved organisation of clinical work **internal** to the Trust	14	1	4	5	8	11	4	47	29.0%
Access to clinical information and information systems	4	3	4	1	4	8	4	28	17.3%
Increased training, CPD opportunities, library access	1	0	1	2	15	7	14	40	24.7%
Staff conditions and remuneration	4	1	1	3	9	3	6	26	16.0%
More effective organisational management	7	2	7	2	9	7	2	36	22.2%
Increased resources (whether £s, staff numbers, equipment)	17	4	1	5	18	13	10	68	42.0%
Better accommodation facilities	3	0	0	0	4	0	0	7	4.3%
Total Comments	55	14	20	19	68	52	41	269	
Average number of comments per responding staff in subgroup	2.2	2.0	2.0	1.7	2.2	3.1	2.4		

Medical Clinicians (25/35)

The doctors' comments indicated that, in 2002 when this survey was conducted, many doctors saw the organisational management strata of the Trust as not involving clinical staff in decisions and not following through on decisions once they were made. The following comments convey the flavour of the concerns about how clinical work was being managed: "Have managers changed into administrators to do the tasks set by the clinicians (ie put the horse back in front of the cart)"[125], "A whole new style of management where important decisions are made following consultation with those involved"[141], "An effective management structure which allows rapid decision making and action to be taken"[140] and "Dramatically reducing the number of meetings which consume a lot of time for non-clinical matters" [134].

Medical Managers (7/9)

Medical managers wanted the wider organisational management to provide a clearer steer on priorities and contractual arrangements especially through the provision of clinical information: "The most important single thing is information in order to support decision making and also to help benchmark performance"[151], "Clarity around contractual arrangements i.e. expectation that unfixed sessions are still meant to be within the NHS"[157] and "Clearer aims of the organisation"[152].

General Managers (10/16)

As noted above, for general managers, clinical performance improvement was dependent upon getting the organisational systems and the prevailing culture right, "More performance monitoring - celebrate success - learn from failure"[165] and "Performance management and team based working - putting patients rather than themselves first"[162] (in this case 'themselves' referred to clinicians). There was a desire to overhaul the management foci, structure and culture to enable the empowering of clinicians, "The development of links between increased clinical performance and resource allocation. Reinforce the role of the Clinical Director to support the principal of devolved autonomy with transparent accountability. Move to an organisational culture in which clinicians are empowered to develop clinical services, supported and guided by clinically aware management structure, Introduction of clinical pathways"[174] and

"Development of leadership skills of clinical staff. Development of team working. Supportive environment where staff are encouraged to learn from mistakes/near misses"[175].

Nurse Managers (11/23)

The two categories of response mentioned most often by nurse managers were increased resources and improved organisation of clinical work internal to the Trust. The desire for extra resources however was often tied to a wise use of these, "Accountability for cost + having to provide 'business case' for using certain products - having to make true evaluation etc"[187] and "Improved staffing numbers in clinical areas to enable more teaching etc to take place"[197]. Nurse managers seemed to believe that general management's controlling emphases were disproportionate to the need and discouraging to front line clinicians: "Lessen management tiers and management as a whole. Staff seem to be unaware of who or which manager does what, Staff are aware of the fact that managers get performance related pay. Have managers who keep in contact with clinical (staff?) setting workload etc. Let go of the purse strings - we are all responsible adults that can budget and know better what is important in clinical settings"[193]. They were also supportive of monitoring, organising and conducting clinical work in accordance with clinical protocols, guidance and peer review.

Nurse Clinicians (31/39)

A large percentage of nurses completed this question, focusing primarily on resources and more personal needs. Many nurses believed they needed increased training and study to increase their clinical performance. For one (apparently very depressed) staff member this was seen as a way out of a hellish situation, "My clinical performance continues to deteriorate etc. Stress of job affected my memory - am botching things up - making some right cock-ups can't think straight and can't form words etc. ....Am applying for study days just to get off the ward - pity the auxiliaries, they don't have that luxury - am boxed in by managers etc"[212]. Although few other nurses showed this level of distress, being overworked, not being valued, and not feeling safe in the workplace seemed to be a common experience. Two indicative comments in this vein were: "Funding for extended roles - nurses not feel cheap source of performing doctors jobs i.e.

consultation"[209] and "Small dirty poorly furnished staff rooms make staff feel undervalued" [227]. Continuing in this vein, many nurses wanted to be able to contribute in clinical performance in ways that boosted their role, responsibility and self-esteem: "I would like to be able to amend disease modifying drug dosage according to patient need"[229], and "More autonomy in decision making"[220].

Allied Health Managers (17/21)

Allied health managers most often mentioned increased resources (usually 'funding' but also time and staff) and the internal organisation of clinical work as means for improving clinical performance in the Trust although increased training and access to clinical information systems were also mentioned. As with the allied health staff in NTH, coordinated approaches to care and multidisciplinary teamwork featured strongly in their suggestions. Possible improvements along these lines included using care pathways, involving patients and carers in service redesign, and care monitoring. They wanted "sufficient staff to enable clinicians to function as part of a known team (as opposed to working with different staff members)"[246], service mapping and "multi-professional management"[260], and "explor(ing) use by different skill mix to enable 'right people' to be able to concentrate on tasks they are best able to carry out"[250].

Echoing other staff groups' comments about the wider organisational management needing to foster a different organisational culture were comments about celebrating "good practice and innovation, creat(ing) a culture of clinical enquiry, facilitat(ing) whistle blowing in a non-blame culture - develop a Trust whistle blowing policy"[255], and "Better/fairer access to research funding for nurses and PAMS"[266].

Allied Health Clinicians (17/19)

Almost all allied health clinicians participating in the survey completed this question (17/19). For allied health clinicians, the factor that was perceived to most likely to contribute to their own clinical performance was greater access to CPD and research activities, "Opportunities to attend courses without paying for them myself and being allowed time off as recompense. Being given time in working day to prepare for presenting lectures etc to outside agencies"[280]. Linked to this was a desire for better

access to useful clinical information and improved organisation of clinical work, "Better info systems to monitor clinical outcomes with facilities for clinical audit within our own unit i.e. pc's/e-mail etc. Admin management seem awash with them but them seem a 'luxury' in clinical areas – 'we will get access to one soon' etc"[287]. This sense that the conditions for allied health staff were relatively poor, particularly in regards promotion, was having an impact on both staff numbers and morale, "Need to stop our high turnover of staff (because there is no progression)"[278] and "Some kind of reward system - a feeling of being valued"[271].

Summary

There appeared to be a general agreement between professions within CHFT that clinical performance could be improved by increasing the availability of resources and by an overall improvement in organisational management. Although the general managers clearly did not agree with the need for greater resources, they did appear to agree with others' belief that the general managers needed to lift their own game. There were some distinctions between professional groups notably the marked negativity amongst some nurses and allied health clinicians and the desire by numbers of these subgroups for greater access to ongoing training.

B. Responses for Improving Staffs' Experience of Work

B1. Improving the Experience of Work North - Tees and Hartlepool Trust

Staff answers to questions about what would improve their experience of work evoked responses along similar lines to those that would improve clinical performance. The responses were coded in a similar fashion and the same caveats apply to the following interpretation. In total there were only half as many comments for this question as there were for the question about improving clinical performance. This was attributable to two factors: with the exception of medical mangers, those completing the question across all sub professional groups made fewer comments and the percentage of nurse managers completing the question fell below 50%. Despite this, it was again apparent that doctors tend to elaborate their frustrations and suggestions in greater detail than most other professions.

The two highest rating categories of suggestions for improving NTH's staff's experience of work were improvements to the internal organisation of clinical work (30.4% of all suggestions) and better pay and conditions (22.8%). However the total number of staff commenting along these lines was notably boosted by a particular professional subgroup. Despite five of the seven staff groupings' mentioning internal organisation of clinical work most or second most frequently, more than a third of staff desiring improved internal organisation of clinical work were medical clinicians. In a similar vein, 42% of comments suggesting strong dissatisfaction about pay and conditions within NTH originated in the allied health profession (both mangers and clinicians.) However, the next most frequent suggestion for improving staff's experience of work, greater effectiveness of organisational management (mentioned by 18.4% of responding staff), appeared to be a common concern across all professional subgroups.

Table 9.3 NTH Respondents' Suggestions for Improving their Experience of Work

	MC	MM	GM	NM	NC	AHM	AHC	Total (x)	
Numbers of respondents in each subgroup completing this question as a percentage of the subgroup that completed the survey as a whole	n= 15/24 (60.0%)	n=4/6 (66.6%)	n=4/14 (28.6%)	n= 7/17 (41.1%)	n=3/18 (16.6%)	n=6/10 (60.0%)	n= 14/16 (87.5%)	n=53/92 (57.6%)	
	Number of Professionals Commenting in Each Professional Subgroup								% of All Respondent Remarking on Each Issue (x/92)
External influences	0	0	2	0	2	0	2	6	6.5%
Improved organisation of clinical work **between heath care organisations**	1	1	0	1	0	0	0	3	3.3%
Improved organisation of clinical work **internal** to the Trust	10	3	2	6	0	1	6	28	30.4%
Access to clinical information and information systems	1	0	0	0	0	0	0	1	1.8%
Increased training, CPD opportunities, library access	2	1	0	1	0	1	0	5	5.4%
Staff conditions and remuneration	5	1	0	2	1	4	8	21	22.8%
More effective organisational management	4	2	1	2	1	2	5	17	18.4%
Increased resources (whether £s, staff numbers, equipment)	9	2	1	2	0	0	1	15	16.3%
Better accommodation facilities	2	0	0	0	0	1	1	4	4.3%
Total Comments	34	10	6	14	4	9	23	100	
Average number of comments per responding staff in subgroup	2.3	2.5	1.5	2.0	1.3	1.5	1.6		

Medical Clinicians (15/25)

As with the previous question, the impression was conveyed through the comments that doctors believed that decision making processes within the Trust were ineffective and would have appreciated better organisation of care and more inspirational, focused management. There were repeated comments along this line covering most aspects of clinical work organisation and organisational decision making. "Conflict resolution to improve in directorate. Stronger/more involved management strategy"[25]. "A clearer pathway to agreeing and implementing new services or improvements. It is difficult to find out where the final decision rests - difficult to know who has to be persuaded on the merits of proposal"[32]. "A clear job plan. Reorganisation of emergency care by people who understand it. Feeling like there is a strategic plan; all we appear to do in this Trust is balance bodies"[10] and "Evidence that the Board/Exec were leading this Trust towards harmonised working (split sites)"[33]. Medical clinicians also wanted more resources. Suggestions concentrated on more doctors and secretaries.

Medical Managers (4/6

The same four medical managers who answered the question on improving clinical work also answered this question. Their primary foci were around the issue of teams and time, either directly or indirectly. After stating that s/he needed the Trust to "Liberate time for clinicians to communicate effectively with each other and with their teams", one medical manager went on to say "I don't know how to encourage clinicians to behave as a team rather than an individual"[39]. Another wanted "better lead management - not having to struggle to have your patients admitted for surgery or cancelled. 24 hour support services. Time to keep up to date on paperwork/arrange meetings to discuss 'quality' issues"[46]. This sense of time poverty was very common across all staff groups but was especially acute amongst medical managers and may be one explanation for the poor overall survey response amongst medical managers.

General Managers

Effective team working was also the route to improved experience of work for some general managers with one suggesting that 'team' was being given lip service only, "Enhanced teamwork in the real sense of the word"[54]. It seemed however that the

majority of general managers lacked ideas about how to improve the experience of work. Very few answered this question and one who did blamed centralised performance measuring for poor decision making, "The NHS is over-bureaucratic with all afraid of taking risks in case they break a rule. The high degree of central control takes authority away from the most suitable positioned to make the right decision"[51]. Not all general managers were blaming of the wider dynamics of the NHS. One general manager wanted "timeout to reflect, learn, discuss"[48] on personal and organisational responses to situations.

Nurse Managers (7/16)

Most nurse managers responding to this question made suggestions about how clinical work could be better organised and managed. As with medical managers, nurse managers were concerned about the problems of time pressure and their experience of teams but also with time and forums for cross-disciplinary and cross directorate meetings: "More time/importance placed on discussing issues with team. Integrated care pathways - close redress with all disciplines"[72], and "I would enjoy having time to have staff meetings during the working day and this would enhance team building etc. Lack of staff is always a problem, if you do have some staff they are always required somewhere else with a higher priority"[74].

Nurse Clinicians (3/18)

A poor response rate from nurses on this question again raises the issue of representativeness in their responses. One nurse thought that the extended nature of the ongoing service review was having a detrimental effect on his/her experience of work. Another nurse felt s/he spoke for others regarding the matter of improved management/staff relations, "More integration/discussion between management and staff in relation to change/staff moves. Recognition from management that staff may want to participate in their own development. Recognition from management that staff have their own views/wants and desires about their future within the Trust"[19].

Allied Health Managers (14/16)

In contrast to the other staff groupings in NTH, the allied health profession's responses about improving their experience of work were marked by a sense of injustice and frustration about their pay and conditions, perceived inferior accommodation, lack of involvement and/or an ineffective voice in clinical decision making, and poor access to training, "An improved environment - why are therapies neglected and housed in poor accommodation on the periphery of the hospital? Recognise the skills of therapists - stop giving posts to nurses to which therapists are more suited"[86], and "Encourage staff and support staff financially to advance their career"[81]. Failure to address these issues was seen by this respondent as being short-sighted on behalf of the Trust management, "Not everyone like me, can be self-financed to complete my course, yet I am moving on to another job. Trust loses out again!!"[81].

Allied Health Clinicians

The allied health clinicians' responses indicated that they were as unhappy at work as their managers however their unhappiness was sourced in the allied health managers, particularly their line managers, rather than the wider internal organisation of clinical work in the Trust. Two representative comments were: "Dreadful line manager in post for years. We manage ourselves"$_{99}$ and "Don't feel 'managed' - come to work - do work - no sense of direction. No reward/thanks to staff as a whole. Put a lot into job, time money (for courses/training) v. little in return, poor job satisfaction. Unable to discuss problems with manager. Poor support mechanisms. Need careers advice/direction. Where do I go?"[97].

A few allied health respondents were more positive, if somewhat frustrated by the failure of either their professional or wider management to implement better care planning especially in regards to discharge processes, "I currently get good job satisfaction with most aspects of my work - although frustrated by poor standards of discharge. Doctors often dictate that a patient is medically fit for discharge - nursing staff will then plan patients discharge date. Would like there to be a Discharge Co-ordinator, who had authority to plan the patients' pathway of care!"[93].

Summary

Staff in all groups believed that decision making processes within NTH were ineffective, resulting in a lack of strategic direction and poor conflict resolution. The effects of this were felt at both organisational and clinical levels of the Trust. As a result, despite increasing governmental pressure for more collaborative, innovative and systems-aware practices in the conduct and organisation of clinical work, staff tended to characterise the Trust as bedevilled by poor team management, lacking in cross departmental and interagency work skills, division between professions, and by poor human relations management. Two troublesome features of the survey were general managers' apparent lack of ideas and the relative failure by nurses to contribute their views on these matters. Given that nursing is by far the largest professional group in the Trust and the strenuous efforts made to include a representative group of nurses in the survey, this absence is concerning. It is perhaps silent testimony to a relative powerlessness of nurses within NTH in accordance with the discussion in earlier chapters.

B2. Improving the Experience of Work - Calderdale and Huddersfield Foundation NHS Trust

Table 9.4 over the page shows that three themes dominated the responses by CHT's staff about how their experiences of work might be improved. These were improvements in staffs' conditions and renumeration (27.8% of respondents), more effective management (28.9%) and increased resources (24.1%). The high rating for the first of these was influenced primarily by nurse clinicians and allied health managers. These groups, together with medical clinicians, were also the driving force behind the prominence of concerns for increased resources. All staff groups however desired more effective organisational management. Staff often saw all three suggestions as being interrelated. Amongst nurses and allied health managers, the common theme was being overworked and under valued (more pay was not listed as a factor that would improve their experience of work).

As with NTH, the volume of suggestions across all staff groups for improving the staff experience of work was lower than that for improving clinical work. The number of

comments by nurse managers and allied health clinicians also decreased noticeably. Unlike NTH, the average number of comments made by responding staff was relatively consistent across the seven professional subgroups.

Medical Clinicians (24/35)

Medical clinicians listed improvement suggestions across all categories of possible responses however the factor favoured by the largest number of medical clinicians for improving their experience of work was increased resources. Increased time was the most commonly desired resource (six mentions); it was also a factor in medical clinicians' desire for better management and the improved internal organisation of clinical work. Perhaps surprisingly, their concerns were often that their face to face clinical time was impeding their ability to become involved in management and develop clinical services and protocols; there was also concern that the time they did spend in management was ineffective due to poor organisational management. The following comment was typical e.g. "Less administration and management *(illegible)* in clinical time. Support to approach the broader service providers - to develop joint progress. Respect for my time boundaries and not organising meetings which fall always on my day off !"[140]. However some believed that changes had been introduced that had benefited junior doctors.

Table 9.4 CHFT Staff Suggestions for Improving their Experience of Work

	MC	MM	GM	NM	NC	AHM	AHC	Total (x)	
Numbers of respondents in each subgroup completing this question as a percentage of the subgroup that completed the survey as a whole	n= 24/35 (68.6%)	n=7/9 (77.8%)	n= 8/16 (50.0%)	n= 9/23 (39.1%)	n= 29/39 (74.4%)	n= 16/21 (76.2%)	n= 6/19 (31.6%	n= 92/162 (56.8%)	
	Number of Professionals Commenting in Each Professional Subgroup								% of All Respondent Remarking on Each Issue (x/162)
External influences	2	3	1	0	1	0	0	7	4.3%
Improved organisation of clinical work **between heath care organisations**	2	0	2	0	0	2	1	7	4.3%
Improved organisation of clinical work **internal** to the Trust	7	1	3	1	3	4	7	26	16.0%
Access to clinical information and information systems	2	1	1	0	0	2	2	8	4.9%
Increased training, CPD opportunities, library access	2	0	0	0	6	0	2	10	6.2%
Staff conditions and remuneration	7	1	2	3	17	11	4	45	27.8%
More effective organisational management	9	3	6	4	10	9	1	42	25.9%
Increased resources (whether £s, staff numbers, equipment)	10	2	0	1	14	5	6	38	24.1%
Better accommodation facilities	3	1	0	1	2	0	1	8	4.9%
Total Comments	44	12	15	10	53	33	24	191	
Average number of comments per responding staff in subgroup	1.8	1.7	1.9	1.1	1.9	2.1	4.2		

Medical Managers (7/9)

The medical managers' responses echoed their colleagues' comments about time, management and organisation of clinical work and work responsibilities. However they also recognised that these facets of organisational life were not always the fault of managers: "Many of us feeling very pressurised - some by the load of clinical work, some by the management work load. Many frustrations arise because of the inability to institute changes which we know would lead to better care and more compliance etc. A lot of the inertia around politics (local) - yet the adverse publicity from gov, and media shows clinicians being resistant to change"[157].

General Managers (8/16)

CHT general managers' belief they had to improve their own game also extended to their assessment of potential improvements in their experience of work. They listed a variety of organisational attributes that needed to be improved. These included providing clear and sound management leadership, attending to organisational culture, being less insular, clearly defining roles and responsibilities, communicating better and using appropriate project management tools such as 'PRINCE' to see their projects through. They also believed that reducing the influence of some external influences would improve their own and others' experience of work. Amongst elements listed were a lessening of the number of targets and the target driven culture and reducing public and governmental criticism of the NHS.

Perhaps of more direct importance for changing the way clinical work was organised in CHFT was the desire by the majority of responding general managers to enable clinicians to lead on clinical management changes. This, it was believed, would impact beneficially on both general managers' and clinicians' working life: "Demonstrate that clinicians are in the driving seat in terms of improving clinical care outcomes. That they will not be left exposed to criticism if managing clinical services. Reduce anxiety and fear of being blamed if mistakes are made. Provide sound management leadership"[174].

Nurse Managers (9/23)

Better performance on basic management responsibilities and work/pay conditions were the two main themes amongst nurse managers. This group seemed very disenchanted with their working lives. The following quote is representative of comments advocating improved management, "Workshops on attitude and leadership development. Team building. Understanding the roles of others. Listening to patient experiences. Face to face resolution with complainants and a mediator"[187]. The following comment exemplifies comments made about staff pay and conditions, "Dedicated ICU nurse 20years + in NHS - I feel I have given a life's work to Trust for very little financial/career reward. Have been 'G' Grade since 1989. The role has changed with more managerial responsibility - less reward more frustration etc"[183].

Nurse Clinicians (29/39)

As noted above nurse clinicians were vocal about their working conditions. They were also keen to have more resources, especially time. They also wanted more responsive management however it is possible that their concern was more for their immediate managers than the organisational management, "Better communication skills between staff/management. Ask the team as a whole their views and opinions regarding patients care and change"[213] and "Managers need to know what works and what doesn't at floor level to boost staff morale if necessary changes to be made etc. Staff need to feel rewarded for the extra effort they make when attempting to cover for staff shortages. If staff felt more valued it would really make a big difference"[237].

Allied Health Managers(16/21)

To a large extent, the tenor of the comments from allied health managers was similar to those made by nurse clinicians. For many, the long list of desired changes in resources was linked to better working conditions and improved clinical organisation. The desired changes included sufficient time to allow clinicians to introduce change, provide clinical supervision, developing strong leadership and support amongst clinicians, and get "the 'hygiene' factors right to improve morale"[255]. These were also linked with improved managerial performance in resolving issues (apparently in clinical management) arising

from the Trust merger, and in vigorously implementing local service agreements in an atmosphere of greater corporate stability.

Allied Health Clinicians (16/19)

These respondents focused on improvements in the internal organisation of work, often within the context of multidisciplinary and inter-service teams and wider clinical support systems. They also wanted increased resources to achieve this and better pay and conditions, including role redevelopment. The following two comments indicate the general tenor of responses: "Clearer team leader organisation to provide direct clinical service developments"[273] and "An extended role into proactive occupational health for Trust staff and vocational rehabilitation as part of multi-disciplinary team. Greater locality focus for my services. Systems of work that enhance the co-ordination of and liaison between intermediate care services (e.g. database)"[283].

Summary

Overall, CHFT staff believed increased availability and better management of resources, especially time, would improve their experience of working life. This was the case throughout the Trust whether at the organisational level, between clinicians and general management, or within clinical units and teams. There was an apparent belief that better use of time would both enable and sustain both clinical and organaitional outcomes. Nursing and allied health professionals gave a strong impression that poverty in time, other resources and effective management was disproportionately impacting on their experience of work compared with other groups. Many staff in these groups expressed strong dissatisfaction with their employment conditions and roles.

C. Staff perceptions about the Role, Operation and Management of hospitals

Respondents were asked how they thought the operation of the local health economy could be improved by each of the various organisational actors within it however, for the purposes of this study, only the question relating to hospitals is relevant. The intention, in both the original study and this one, was to gain insights into how hospital staff thought about their Trust, its role, operation, and management, in relation to other organisations.

C1. Improving the Health Economy - North Tees and Hartlepool NHS Trust

The three most common responses by far within NTH participants were improved organisation of clinical work between health care organisations (33.7%), improved organisation of clinical work internal to the Trust (33.1%) and more effective organisational management (29.3%). Interestingly whilst most professional subgroups supported the need for improved organisation of clinical work across the health economy, medical mangers did not.

This was the one free form question in which NTH medical clinicians' propensity to criticise and suggest improvement options was relatively subdued (average of 2.4 comments per answering clinician). The allied health professions, both managers and clinicians (2.8 and 2.7 average comments per answering staff member) were more forthcoming with suggestions. They were equalled in this suggestion rate by the general managers (2.8).

Table 9.5 NTH Staff Suggestions For How The Operations Of The Local Health Economy Could Be Improved By The Trust

	MC	MM	GM	NM	NC	AHM	AHC	Total (x)	
Numbers of respondents in each subgroup completing this question as a percentage of the subgroup that completed the survey as a whole	n= 12/24 (50.0%)	n=5/6 (83.3%)	n=5/14 (35.7%)	n= 12/17 (70.6%)	n=2/18 (11.1%)	n=6/10 (60.0%)	n= 9/16 (56.3%)	n=51/92 (55.4%)	
	Number of Professionals Commenting in Each Professional Subgroup								% of All Respondent Remarking on Each Issue (x/92)
External influences	5	1	2	1	0	2	0	11	12.0%
Improved organisation of clinical work **between heath care organisations**	8	0	6	5	0	9	3	31	33.7%
Improved organisation of clinical work **internal** to the Trust	2	3	3	10	0	2	6	26	31.6%
Access to clinical information and information systems	1	0	0	0	0	1	0	2	2.2%
Increased training, CPD opportunities, library access	0	0	0	0	0	0	1	1	1.1%
Staff conditions and remuneration	1	0	0	2	1	0	3	7	7.6%
More effective organisational management	5	3	3	6	0	2	8	27	29.3%
Increased resources (whether £s, staff numbers, equipment)	7	0	0	3	1	1	3	15	16.3%
Better accommodation facilities	0	0	0	1	0	0	0	1	1.1%
Total Comments	29	7	14	28	2	17	24	121	
Average number of comments per responding staff in subgroup	2.4	1.4	2.8	2.3	1.0	2.8	2.7		

Medical Clinicians (12/24)

Medical clinicians had a variety of suggestions for better health economy functioning and improved functioning of the hospital as part of that. The tenor of their responses implied that previous reorganisations had not been handled well by hospital management, leading to division amongst clinical staff and impaired provision for patients. There was hope by five doctors that the arrival of PCTs might provide a means to redress this: "All three groups need to sit down together and develop a coherent and sensible plan to provide a good service. Splitting them up is divisive and leads to a culture where delays can always be blamed on someone else. There should be much more joint working in many areas. Individuals who are working at grass roots need to meet each other rather than managers and directors meeting who have little understanding of the practice problems involved. To be frank the amalgamation of the H'Pool and NTees Acute Trusts has not been helpful and this needs to be sorted out"[10], "For paediatrics, due to child's ever changing needs, stability and consistency of his carers and service providers is very important. I think the concept of GP allocation for a family should be extended for general paediatricians and social service team allocation. This could be patch-based with corresponding GP areas"[6].

However medical clinicians also believed that more resources and improved decision making about their use (where resources should be held and which organisation should make decisions about how those resources should be used) were key. There was doubt that the hospital (managers) would be able to ensure the Trust functioned decisively and effectively and concern that PCTs would 'inappropriately' drive service changes in the hospital, "Although need funding from somewhere PCTs are not the answer. PCTs interests lie in Prim.Care, not in emergency or Sec. Care. The budget should be developed to the hospital Trust to use as they feel appropriate with dialogue regarding services for PCT. Then any reconfigurations will not be spiked by PCTs withdrawing funding e.g. from sub-regional specialities (e.g. vascular surgery)"[12]. Implied or stated mismanagement, especially in resource use and/or a lack of effective communication and consultation, and an associated 'skewing' of services towards the meeting of external objectives (whether PCT or DoH imposed) was a common theme in doctors' responses and provoked some strong comments. As an example, "Introduce

'business' + patient focused thinking and more joined up working to reduce waste of time/resources. Quality NOT Quantity targets i.e. freedom from dictates from the Centre. Debate (with the public) about what can be provided and what cannot/will not meet expectations"[33].

Medical Managers (5/6)

Medical managers were concerned for only two areas of action - improved internal organisation of clinical work and improved Trust management. Only one medical manager was positive about the direction provided by the Trust management but, even so, noted there were important service issues to be addressed. Comments ranged from simple statements of perceptions about what needed to be done, "24 hour/7 day week services, especially for diagnostic tests. Out of hours 'out patient' appointment to meet patients needs"[40] to rather condemnatory statements about internal management for several functional departments, "Listen to people - I could have masses of money if common sense rather than political paranoia was used to help decision making"[43] and "Management of HR, Estates and IT all need reorganisation. The reconfiguration indecision is leading to drift and we are losing good staff"[42].

General Managers (7/14)

General managers placed most emphasis upon partnership and joint organisational working within the health economy, even at times to the point of wanting to subsume primary care under the acute Trust's auspices, "The merger of PCTs under the umbrella of the local Acute Trust - this will reduce tiers of management and ensure better co-operation and management of financial resources reducing comp. for finance"[53]. Only two of general managers however made comments which could be considered as taking proactive ownership of the Trust's management issues, "Must meet reconfiguration head on whatever the outcome, take the staff through it and re-stabilise"[54].

Nurse Managers (12/17)

Nurse managers' suggestions for how the Trust could contribute to improved health economy functioning ranged across most response categories and were primarily lists

of aspects of service which apparently were not occurring at that time. They included specific service initiatives - one stop diagnostic centres, the use of pathways, patient focused care, fast tracking of clients to appropriate care, 24 hour availability of support services (pharmacy, investigative labs, OT.s, Physios etc) - and more generic matters such as reviewing allied health professionals input and preventing unnecessary admissions via A/E. In this sense, nurse managers made the most concrete suggestions for improving the organisation of clinical work both within and without the Trust.

Four nurse managers also made comments that were more about the *way* in which clinical work was structured, conducted, managed and rewarded. They suggested that reshaping the Trust management structures and developing leadership were ways forward, "Capacity planning and management needs to be looked at (balancing emergency and planned care) - maybe a review of structures of directorates may help"[69], and "More emphasis in the role of the clinical leader - investing in programmes such as the RCN Clinical Leadership Programme"[72].

Nurse Clinicians (2/18)

Only two of eighteen responding nurses answered this question, which again suggested that either nurses did not have any opinions or, more likely, that nurses were disenfranchised and disinterested. These responses were restricted to financial issues and staff conditions.

Allied Health Managers(7/10)

As noted above, most of the allied health managers' comments related to the organisation of care across the health economy. The comments concern the full range of inter-organisational working including trust, vision, finance and information sharing for example, "Proper identification of budgetary requirements, acceptance of responsibility and integration of funding required across all 3 orgs"[79] and "Cooperation, planning between both Trusts. IT Information - between PTCs GPs SSs"[83]. The remainder of the comments suggested disenchantment with work and/or the way the Trust was managed, "Ensure fair distribution of funding, Less change - more stability,

Listen to staff of all disciplines, Take notice and acknowledge input of smaller professional groups and involve in planning processes"[85].

Allied Health Clinicians (9/16)

Most AHP respondents were concerned with how care was organised and what they regarded as poor management both within the profession and within the hospital rather than with health economy-wide concerns, "How much management do we actually need? My manager seems to write an excessive number of reports"[104], "Need to feel that staff are important, not just managers. Less criticism, more praise"[94], "Better communication within teams/managers and also between teams/disciplines"[97]. One allied health clinician felt strongly that efforts to involve patients in Trust and clinical decision making was an impediment to effective functioning. The Trust should "make patients more aware of their responsibilities to make the most of what they are offered by the NHS... they should adhere to rules"[90].

Summary

Staff in NTH (especially doctors) were concerned that previous organisational restructuring in pursuit of improved functioning of the local health economy, particularly the amalgamation of the two precursor NHS Trusts, had not been well handled. They were fearful that additional restructures in primary care would contribute to the resulting problems and that NTH management would unable to positively influence the resulting organisation of care, either within or across organisations. Hence many suggestions were aimed at 'fixing' NTH rather than the health economy. Suggestions to improve both included better communication and team work (again within and across organisations), strengthening leadership, reorganising Trust management, and subsuming primary care activities into the acute care Trust.

C2. Improving the Health Economy - Calderdale and Huddersfield NHS Foundation Trust

Staff in CHFT were less concerned with joint health economy working than were staff in NTH. CHFT tended to favour more effective CHFT management (25.3% of respondents) as the best means to contribute to the improved working of the health

economy, followed by improved internal organisational of work (20.4%) and then improved organisation **between** health care organisations (17.9%).

This question was answered by less than half of CHFT respondents. The only professional subgroups in which more than 50% of respondents completed the question were general managers (56.8%) and nurse clinicians (53.8%). Only general managers appeared to have multiple ideas each (2.9 average) about how the hospital could contribute to the health economy however, whilst they did provide suggestions for improving clinical work organisation across the health economy, they were more inclined to the Trust's contribution lying in the realm of improvements to its own internal management. In general, the responses which were made in answer to this question were less sub-profession specific than NTH staffs' responses.

Medical Clinicians (15/35)

Only 43% of medical clinicians in Calderdale Huddersfield NHS Foundation Trust who completed the questionnaire completed this question. Though the doctors' comments ranged across a variety of possibilities, suggestions focused primarily upon improving management's capability to deliver good internal clinical and organisational management. Medical clinicians wanted less time spent on nationally determined targets and more on identified local needs, "Management to listen to local clinicians and facilitate local clinical issues rather than work towards centrally dictated targets"[130] and "Empower the clinicians - involve them in discussing finances, targets etc. Tell them the figures, don't assume it's too complex for you, and don't plan changes without consultation"[125].

They were not 'precious' about their own services. Amongst the suggested specific service development initiatives were "Plug the gap in the clinical need area e.g. radiology and pathology. Establish non-trauma GP centres to reduce pressure on A&E Departments"$_{130}$ and "Review pathways into acute care and have better integrated care pathways between primary and secondary care"[117]. One doctor felt the hospital should look extra-nationally for ensuring that the hospital contributed effectively to the local health economy, "I feel all three services should have a unified management and

budget as in Northern Ireland. We should also look at the French model of health care delivery"[138].

Medical Managers (4/9)

Three of the four medical managers answering this question commented on the need for complementarity and clarity between the primary and secondary care sectors, "Clear aims and roles in primary and secondary care"$_{152}$. In more detail, "Reconfiguration of services needs to happen. Demand needs to be managed by primary care – the impact of NHS Direct has been to take pressure off primary but has sent more to A&E - therefore needs to be looked at"[157]. The fourth medical manager simply noted that the Trust required "Adequate staffing and information technology"[154]. Internal management was not seen to be an impediment to the achievement of these.

General Managers (9/16)

General managers' responses to this question were wide ranging and at times, almost visionary, "Complete redesign of service provision, we can do things differently and provide a good, if not better, service to patients. Work with partner /organisation/the broader health community to improve service across the patch"[168] and "Local autonomy on performance - becoming a 'foundation system'. Average European funding"[167]. A third of general management respondents thought that the Trust should focus upon improving collaborative working within the Trust, particularly in terms of marrying financial and clinical matters and introducing a more patient oriented approach, "Clear financial personnel clinical framework within which clinicians can lead and develop services. Demonstrate that funding will follow patients wishes/choice tin the future. This will enable a more proactive clinical attitude to service delivery to develop"[174] and "Change emphasis from looking at budget variances to value for money analysis. Emphasise good performance - encourage people to try different approaches to service delivery and measure outcome etc etc. Patient led services not staff led"[165]. One general manager however was doubtful, "I'm not convinced that the current reforms/structure will have the devised effect in enhancing overall patient care"[163].

Table 9.6 CHFT Staff Suggestions For How The Operations Of The Local Health Economy Could Be Improved By The Trust

	MC	MM	GM	NM	NC	AHM	AHC	Total (x)	
Numbers of respondents in each subgroup completing this question as a percentage of the subgroup that completed the survey as a whole	n= 15/35 (42.9%)	n=4/9 (44.4%)	n= 9/16 (56.3%)	n= 10/23 (43.5%)	n= 21/39 (53.8%)	n= 9/21 (42.9%)	n= 7/19 (36.8%	n= 75/162 (46.3%)	
	Number of Professionals Commenting in Each Professional Subgroup								% of All Respondent Remarking on Each Issue (x/162)
External influences	0	0	2	0	0	0	0	2	1.2%
Improved organisation of clinical work **between heath care organisations**	5	3	7	3	3	5	3	29	17.9%
Improved organisation of clinical work **internal** to the Trust	7	0	3	6	8	5	4	33	20.4%
Access to clinical information and information systems	1	1	1	0	0	1	0	4	2.5%
Increased training, CPD opportunities, library access	0	0	0	0	2	2	0	4	2.5%
Staff conditions and remuneration	2	0	2	2	3	0	0	9	5.6%
More effective organisational management	8	0	9	6	12	4	2	41	25.3%
Increased resources (whether £s, staff numbers, equipment)	3	1	2	3	6	1	1	17	10.5%
Better accommodation facilities	0	0	0	0	0	0	0	0	0
Total Comments	26	5	26	20	34	18	10	139	
Average number of comments per responding staff in subgroup	1.73	1.3	2.9	2.0	1.6	2.0	1.4		

Nurse Managers (10/23)

Though less than half of responding nurse managers answered this question, those that did also focused primarily upon the internal restructuring of clinical services and organisational management. There were suggestions that restructuring services should entail changed working conditions for doctors and nurses alike with an implied criticism of the dissimilarity between the two professions' status and working conditions, "Strong leadership in all levels but a flat structure without hierarchy e.g. doctors are taken more notice of than other professionals"$_{187}$ and "More flexible ways of working. Better use of surgery time. Round the clock working (A lot of time is lost at BHs, weekends etc). Doctors to work shifts like nursing staff."[183]. More flexible working across the professions was thought to work to patients' benefit, "Outpatient clinic to be in the evenings or Saturday morning. Keeping to a rigid system for appointment times doesn't help patients"[194]. Three nurse managers thought undervaluing of staff led to problems with commitment which led to problems with the provision of care within and across organisations, "Strongly believe that all problems in NHS eventually stem back to poor pay & undervaluing of all NHS staff (nurses, doctors, PAM's, scientists etc) & will not be resolved until this is addressed. Understaffing impacts on all factors from amount of hospital acquired infection to lack of time for education, clinical governance etc. to poor quality care"[197].

Nurse Clinicians (20/39)

In contrast with NTH in which nurses' voices were largely absent, CHFT nurses responded relatively freely to this question. The nurses' comments indicated their assessment of how improvements could be made was similar to those of their managers. The comments emphasised service improvement possibilities – there were surprisingly few comments about more resources. Some nurses demonstrated strategic thinking, "Good assessment of existing services identifying the gaps & short term objectives/goals before a long term strategy is planned"[236] whilst others had innovative ideas about what could change.

The tenor of several nurses' comments however was more negative than those from nurse managers. Several nurses were critical of management initiatives including

attempts to involve clinicians in management, "The Acute Trust needs to look critically at the management structure and evaluate. Look at how many managers the Trust actually needs. Putting clinicians in management roles without adequate support and training does not always produce good managers"[208] and "Management - clinical effectiveness meetings - relationships between management and basic staff are points of concern"[209]. Strain was evident in several nurses' responses. For example, "We are running scared of litigation, unrequired treatments are pursued for fear of missing something never present. We need a degree of protection from legal vultures and the public need to stop being fed stories re Allitt and Shipman. We work in the NHS to help people, or the vast majority do"[217].

Allied Health Managers (11/21)

Though allied health managers commented on a number of areas, they were very aware of how hospital care fitted into the wider care picture, what could be done to improve that fit and, with it, care delivery for patients across the health economy as a whole, "Focus on what they (hospitals) do well - secondary care. Understand primary care wishes better and work more harmoniously with the community at large"[255], "Liaise better with GPs re chronic care of patients - pass long term patients back to PCTs - give more to CMOs. Liaise better with tertiary centres - communication is poor and often therapists are the communication route"[252]. It was evident that allied health managers felt few in the hospital understood the contribution they and their staff could make in this regard: "Use our service appropriately. Understand our role and policies - not to just fill in referrals for the patient....We are not running a beauty service but they do use us that way!!!"[249]. Perceived inequities/poor uses of NHS staff resource were not limited to the Trust – services "Should be equitable across the country e.g. access to ???/pulmonary rehabilitation"[256] and efforts should be made to ensure that "Consultants that work for the NHS do just that and not use NHS time for private work! It still goes on" [264].

Allied Health Clinicians (6/19)

Allied health clinicians' comments were essentially divided between what the Trust needed to do internally and what it needed to do in conjunction with other organisations

in the health economy. Innovative, strategic and capable thinking was desired, "Preparedness and capability to negotiate appropriate service provision with other stakeholders in a locality and transparent willingness to think outside the box! Organisational stability so as to generate the confidence to achieve the above" and "shared care"[283]. Such thinking was not just about the types of service provision but how it might be funded. "It (local health economy functioning) may be better if there were not competition between services i.e. if funding was from one source for all so that the patients needs could be addressed without the question 'who pays for it'. The interfaces need addressing between services- perhaps some more funds like joint contingency funding that can be used etc"[288].

Summary

On the whole all staff subgroups showed an awareness of the Trust's role and linkages within the wider health economy. The greatest contribution staff thought CHFT could make to the functioning of the wider health economy however was via improvements to its own internal management and functioning. Staff from all groups demonstrated a capacity to think both innovatively and strategically in seeking these improvements although there was also concern amongst all groups about whether the Trust management could provide adequate support to innovative programmes and work practice changes.

D. Comparative Overview of Professional Subgroups

Chapter Eight suggested that there were consistent patterns of difference in values and conceptions of clinical work between the various professional subcultures such that there is greater similarity between the same subgroups across sectors than there is amongst subgroups within the same sector. This being so, it could be expected that the professional subgroups in the two study Trusts would show would show similarities in their thinking about the priority of needs and suggested improvements. Alternatively, part of the explanation for the different outcomes between the two Trusts may lie in attitudinal differences between the two Trusts' staff.

Table 9.7 uses a thematic approach to summarise the professional subgroups' stances in some detail. It shows that the *medical clinicians* within the two Trusts by and large took similar stances about the need to improve the internal organisation of work and resource availability, with some differences in emphasis in between the two groups. Both staff groups doubted management's ability to deliver required changes; in NTH the doubts were appeared strengthened by poor experiences of past amalgamations and decision making processes.

Medical managers echoed the medical clinicians in both Trusts however they were less critical of management and seemingly 'reversed' the medical clinicians' emphasis upon health economy concerns. They were keen to introduce changes that would allow them to better balance the differing responsibilities of their positions and to have a stronger information base for decision-making about clinical priorities, service design and contractual commitments. They differed primarily in their emphasis upon teams and team working and the effect of local politics upon internal decision making and reform.

Table 9.7 Summary of Sub-Professional Stances on Improvement Strategies Within and Between Trusts

	North Tees and Hartlepool NTH Trust	Calderdale and Huddersfield NHS Foundation Trust
Medical Clinicians	Emphasis on: • Improvement of the internal organisation of clinical work within the Trust • Increased resources and improved decision making about their use • More effective organisational management Despite this comments were wide ranging over the various categories of responses. Believed: • Decision making processes within the Trust were ineffective • Past amalgamations had been poorly handled Would have appreciated: • More inspirational and focused management • Better health economy functioning Appeared to doubt that: • The hospital (managers) would be able to ensure the Trust functioned decisively and effectively in new health economy environment	Emphasis on: • Increased resources • Improved internal organisation of clinical work Comments were wide ranging over all categories of possible responses however the resource in highest demand was time. Believed: • Management should empower the clinicians • More focus was required on identified local needs Would have appreciated: • Improvements in management's capability to deliver good internal clinical and organisational management

Medical Managers	**Emphasis on:** • Improvement of the internal organisation of clinical work within the Trust • This was a matter of making better use of the resources the Trust already had. **Would have appreciated:** • More time for both clinical work and management activities • Better access to clinical information to guide and inform service design and delivery • Greater emphasis upon teams • Greater skills development of team management and team working	**Emphasis on:** • Organisational management to provide a clearer steer on priorities and contractual arrangements **Would have appreciated:** • More time for both clinical work and management activities • Better access to clinical information to guide and inform priorities and contractual arrangements • Greater complementarity and clarity between the primary and secondary care sectors **Concerned about:** • Inertia resulting from local politics
General Managers	**Emphasis on:** • Reorganisation of internal work **Concerned to:** • Rein in power of the consultants **Would have appreciated:** • Effective team working within organisation • Partnership and joint organisational working within the health economy **Characterised at times by**: • Some blame shifting to DoH, clinicians • Apparent lack of ideas to resolve difficulties Redesign of health economy organisation of care strongly supported – even to point of subsuming aspects of primary care under the acute Trust's auspices	**Emphasis on:** • Getting the organisational systems and the prevailing culture right • Empowering and enabling clinicians to take the lead **Concerned to:** • Improve their own game **Would have appreciated:** • Reducing the influence of some external influences **Characterised by:** • Criticism of own performance • Listing a variety of organisational attributes that needed to be improved • Absence of blame on clinicians Redesign of service provision within health economy less of a focus- would have preferred focusing on developing collaborative working *within* the Trust

Nurse Managers	**Emphasis on:** • How clinical work could be better organised and managed **Believed:** • Clinical performance outcomes were related to virtually all aspects of organisational life. This extended to cross organisational performance as well. **Concerned about:** • Time pressures • Lacks in experience in working in and leading teams, forums for cross-disciplinary and cross directorate meetings **Would have appreciated:** • Efforts to reshape the Trust management structures and developing leadership **Characterised by:** • Concrete suggestions (i.e. Not abstracted ideas) for new service developments	**Emphasis on:** • Increased resources • Improved organisation of clinical work internal to the Trust **Believed:** • General management's controlling emphases were disproportionate to the need and discouraging to front line clinicians • Undervaluing of staff led to problems with commitment **Concerned about:** • Their own and general management's ability to undertake basic management responsibilities • Work/pay conditions **Would have appreciated:** • Internal restructuring of clinical services and organisational management • Associated changed working conditions for doctors and nurses *alike*
Nurse Clinicians	**Emphasis on:** • Pay and staff conditions **Concerned about:** • Accessing more training opportunities • Sorting out anomalies in working conditions • Poor management/staff relations **Characterised by:** • Extremely low response rate • Appeared disengaged with organisation; emphasis upon personal development and needs	**Emphasis on:** • More resources, especially time • Working conditions • Service improvement possibilities **Concerned about:** • Personal needs especially increased training and study **Characterised by:** • Apparent strong discontent with their immediate managers, more so than the organisational management • Negativity within comments; • Evident strain; two appeared close to suicidal

Allied Health Managers	**Emphasis on:** • The organisation's relationships with external bodies • Organisational requirements for improved clinical organisation (on which they had wide ranging views) **Believed:** • The availability of resources was important , particularly time which they felt could be achieved either through more staff or the reorganisation of clinical work **Concerned about:** • The role of the allied health profession within the organisational structure • Lack of involvement and/or an ineffective voice in clinical decision making • Pay and conditions • Perceived inferior accommodation • Poor access to training **Would have appreciated:** • More organisational focus and effort on the full range of inter-organisational working including trust, vision, finance and information sharing **Characterised by:** • Disenchantment with work and the way the Trust was managed	**Emphasis on:** • Increased resources (usually 'funding' but also time and staff) and the internal organisation of clinical work • How hospital care fitted into the wider care picture, what could be done to improve that fit **Believed:** • Issues of resource availability were also linked to issues about improved clinical organisation and better working conditions **Concerned about:** • Developing more coordinated approaches to care • Developing multidisciplinary teamwork **Would have appreciated:** • Improved managerial performance in resolving issues (apparently in clinical management) arising from the Trust merger • Organisational management fostering a different organisational culture **Characterised by:** • Concern about the wider organisation of care

Allied Health Clinicians	**Emphasis on:** • Better access to training • Improvements to both the organisation of clinical work and organisational management • More resources **Concerned about:** • Difficulties in working in 'integrated' teams (although supportive of these) • Poor management both within the profession and within the hospital rather than with health economy-wide concerns • Better care planning especially in regards to discharge processes **Characterised by:** • Deep unhappiness with their allied health line managers, particularly their managers	**Emphasis on:** • Internal organisation of work • Poor conditions particularly in regards promotion **Concerned about:** • Greater access and fairness to training, CPD and research activities • The context of multidisciplinary and inter-service teams • Clinical support systems **Characterised by:** • Equal concern for what the Trust needed to do internally and what it needed to do in conjunction with other organisations in the health economy • Innovative, strategic and capable thinking about improving cross disciplinary and intersectoral work

General managers were the professional subgroup that demonstrated the greatest difference between the Trusts. General managers in CHFT could be characterised as having clear organisational goals, agreement about the desired culture within the Trust and ideas about how to do things differently. They were seeking a much more inclusive approach to management, wanting to empower clinicians in 'leading' design of services and clinical management systems. They agreed with other professions about their failings and emphasised their need to lift their own game. In contrast, general managers in NTH, though concerned to improve effective team and joint working within both the organisation and within the health economy, seemed to lack ideas for doing so and tended to blame shift on to clinicians, external politics, and previous reorganisations of care.

Nurse managers in both Trusts emphasised the organisation and management of care in their responses. NTH nurse managers however widened their concern to take in the local health economy, making many concrete suggestions about how care provision could be improved. Time pressures were a common concern amongst the Trusts' nurses as were doubts about abilities to undertake management functions, especially in teams. Nurse managers in NTH would have appreciated greater efforts being made to restructure senior management and develop leadership throughout the Trust. Nurse managers in CHT desired restructuring that led to change and more equivalent working conditions between nurses and medical professionals.

The *nurse clinicians* seemed to have similar concerns between Trusts though the very low response rate by nurse clinicians in NTH meant any generalisation about their views is, at best, tentative. Nurses were mostly concerned with personal aspects of working life especially pay and working conditions (time pressures again featured prominently) and having greater access to training opportunities. Both groups of nurses appeared to be very unhappy with their employment. In CHT this was manifested in particular unhappiness with their immediate line managers; in NTH it appeared to manifest in complete disengagement.

Allied health managers in both Trusts were concerned about how care was organised internally and how this related to the organisation of care across each health economy. They were also concerned about the interconnections between resource availability, the organisation of care, and working conditions. Both groups would have appreciated changes in organisational culture and improvements in managerial performance however allied health managers in NTH were particularly disenchanted with how the profession was viewed within the Trust.

Allied health clinicians tended to portray broadly similar views to their managers with additional concerns for increased training opportunities and the operation of multidisciplinary teams. The groups differed in their attitudes and outlook however. Allied health clinicians in NTH were very negative and pessimistic about the Trust's and their own immediate managers. Their counterparts in CHFT were more optimistic about the future and were innovative and strategic in their ideas for future change.

Summary

In general, the results appeared to support the previous chapter's finding of sub-professional differences in priorities and concerns. At times this extended to sub-professional differences in emotional outlooks. These differences were related, in part, to their organisational role and focus. The groups seemingly most disaffected and despondent were the nursing and allied health professionals who, as broad groupings, saw themselves as disadvantaged in their access to the training and professional development opportunities that would bolster their confidence and contributions to their Trusts. Several staff in these groups in both Trusts displayed a hopelessness and despair that suggested they were clinically depressed. There were however differences between the Trusts in the sources and severity of the unhappiness. The group that showed most dissimilarity in concerns and outlooks between the two Trusts were the general managers. General managers in CHFT seemed to be characterised by a realistic assessment of their previous and current performance and by an inclusive and perhaps optimistic outlook about what could be achieved within the Trust, particularly through empowering clinicians to lead. General managers in NTH in contrast were

much less self-critical, more negative about clinical staff and seemingly lacking in ideas about how to move forward.

E. Comparative Overview of Trusts

E1. North Tees and Hartlepool NHS Trust

Table 9.8 provides a comparative summary of the percentage of staff supporting particular improvement strategies in each Trust and ranks improvement strategies in terms of percentage support. (It does not however portray attitudinal outlook). It shows that in NTH the most common amongst staff was improvement to the internal organisation of work. A third of responding NTH staff supported improvements to the internal organisation of clinical work. This was 41% more than the number of staff supporting better management and increased resources, the next two most popular responses. Improved working within the health economy and addressing external influences upon the Trust were rated in the top four concerns in NTH (they were amongst the lowest four in CHFT). Staff ranked support for improved pay/working conditions in the mid range and put least emphasis upon accommodation issues. Perhaps somewhat surprising, given the concerns for improved organisation of work and more effective management, was the relatively little support by staff for better access to clinical data, information systems and training opportunities.

The table cannot however depict differences in organisational 'flavour' between the Trusts. The previous sections' discussions suggest that NTH staff tended to be more negative than staff from CHFT. This was apparently associated with a belief that previous organisational restructuring in pursuit of improved local health economy functioning, and especially the amalgamation of the two precursor NHS Trusts, had not been well handled. Staff assessed the Trust as lacking internal strategic direction and having poor conflict resolution mechanisms hence it would have experienced difficulty resolving any tensions that may have arisen from the disparate stances each staff group adopted over ways forward. Perhaps not surprisingly, staff were apparently fearful that additional restructures would add to existing problems in the organisation of clinical work, organisational decision making and internal communication. These fears

may not have been irrational given that NTH general managers' apparently lacked ideas to address these problems.

E2. Calderdale and Huddersfield NHS Foundation Trust

Table 9.8 shows that staff in CHFT saw the Trust's best way forward as lying in the increased availability of resources, especially time, and an overall improvement in organisational management's effectiveness. Though many staff had suggested innovative ways forward, there was concern that management would be unable to implement and support the suggested improvements. In CHFT the improvement strategies drawing most staff support were increased resources and better organisational management. These were followed by improvements to the internal organisation of clinical work, better pay and conditions, and better training opportunities. Improvements originating in external factors received relatively little support in CHFT. As with NTH staff, CHFT staff ranked support for improved pay/working conditions midrange also rated better access to clinical data, information systems and training opportunities.

Despite the highly negative, even suicidal outlooks, amongst nurse clinicians in CHFT, overall the various staff groupings within this organisation portrayed more positive outlooks than staff in NTH with numbers of staff in each group, even those usually considered relatively powerless, offering a range of innovative suggestions and thoughtful comments. The prevalence of these comments throughout the staff suggested that, though there ware clearly problems to be addressed and some doubt about the Trust management's capacity to achieve it, hope and vision persisted throughout the organisation. The general managers' willingness to involve front line clinicians and to confront their own weaknesses and poor performance suggested that the doubt about management's capacity may have been misfounded.

Table 9.8 Comparison of Percentage Frequency of Comments between Trusts, by Category

	NTH					CHT				
	Percentage of all respondents mentioning each item as a means of performance improvement for each question				Item Rank Overall	Percentage of all respondents mentioning each item as a means of performance improvement for each question				Item Rank Overall
	Clinical Perf	Exp of work	Health Econ	Aver over 3 Qns		Clinical Perf	Exp of work	Health Econ	Average over 3 Qns	
External influences	3.3%	6.5%	12.0%	**10.8**	**6**	3.1%	4.3%	1.2%	4.3	8
Improved organisation of clinical work **between heath care organisations**	12.0%	3.3%	33.7%	16.3	**4**	6.8%	4.3%	17.9%	9.7	6
Improved organisation of clinical work **internal** to the Trust	35.9%	30.4%	31.6%	32.6	**1**	29.0%	16.0%	20.4%	21.8	3
Access to clinical information and information systems	18.5%	1.8%	2.2%	7.5	**8**	17.3%	4.9%	2.5%	8.3	7
Increased training, CPD opportunities, library access	19.6%	5.4%	1.1%	8.7	**7**	24.7%	6.2%	2.5%	11.1	5
Staff conditions and remuneration	12.0%	22.8%	7.6%	14.1	**5**	16.0%	27.8%	5.6%	16.5	4
More effective organisational management	21.7%	18.4%	29.3%	23.1	**2**	22.2%	25.9%	25.3%	24.5	2
Increased resources (whether £s, staff numbers, equipment)	34.8%	16.3%	16.3%	22.5	**3**	42.0%	24.1%	10.5%	25.6	1
Better accommodation facilities	2.2%	4.3%	1.1%	2.5	**9**	4.3%	4.9%	0	3.1	9

Table 9.9 Percentage of Staff in Each Trust Advocating Patient and Team Focus Across All Three Questions

	MC	MM	GM	NM	NC	AHM	AHC	Total Numbers	Total Respondents (%)
NTH (% staff)									
Patient Focus	1.9	2.9	1.9	3.8	0	2.9	1.9	16	15.2
Improved Patient care (without mention of patient involvement)	2.9	1.9	0	0.9	0.9	1.9	3.8	13	12.3
Integrated Clinical Pathways	0	0	0	2.0	0	0.9	0.9	5	4.8
Teams/Multidisciplinary/Joint working	5	3.9	3	8	0	1.9	2.9	24	22.6
CHT (%staff)									
Patient Focus	1.8	0	4.2	1.2	1.8	1.8	1.2	21	12.9
Improved Patient care (without mention of patient involvement)	6.0	0.6	0.6	2.0	7.8	1.2	4.2	37	22.7
Integrated Clinical Pathways	1.2	0	0.6	0	0.6	0.6	0.6	6	6.1
Teams/Multidisciplinary/Joint working	3.6	0	2.4	1.8	3.0	1.8	2.4	25	15.3

F. Patient Inclusion in More Planned Ways of Working

Table 9.9 shows that within both Trusts the desire to increase the patient focus of the organisation was relatively weak. In total, over all three questions, at most only 15% of surveyed staff (and that in NTH) thought greater prominence should be given to patient perceptions of need and priorities as a means towards service improvement. This was particularly the case in CHFT where 25% more staff preferred to define what *they* thought were acceptable services for patients rather than to suggest including patients' in those decisions. Staff were more supportive of multidisciplinary team based working as a means to improve services and experience of work (22.6% in NTH and 15.3% in CHFT) however at most only 6% of staff (and that in CHFT) viewed integrated clinical pathways as a mechanism for achieving this. Thus one of the most supported methods in the professional literature for introducing more patient focused and multidisciplinary approaches to the coordination and delivery of care had relatively little support within both organisations. This is not to say that other approaches were being considered but, if they were, it was not evident in the staffs' responses.

If staff in this study were representative of staff elsewhere in the NHS and/or other western healthcare systems, it would appear that one reason why patients and carers experienced the disjointed care described in Chapter One is that few staff saw the need to focus upon the patients' desires for more 'joined up' care. Further, allied health staff who were the professional group most passionate about more integrated patient care, saw themselves as being relatively powerless within their organisations, poorly managed and/or lacking adequate training to fulfil their roles. On the other hand, in CHT the highest percentage of responding staff suggesting integrated care pathways as a way forward were medical staff. ICP support was also mingled throughout other staff subgroups including the general managers. Such support was not forthcoming from either group in NTH. This suggests that though ICP supporters were numerically small in CHT at the start of the CMD project, if ICPs were to be successfully introduced in either Trust, it would have been more likely to occur within CHFT.

Discussion

The results in this chapter yielded some surprises whilst others conformed to expectations. Overall the support for more patient centred approaches to service improvement was relatively weak in both Trusts. Staff in NTH appeared somewhat more willing to adopt genuinely patient focused improvements than staff in CHFT. The similarity of stances on reform issues within professions, irrespective of organisation, discussed in Chapter Eight was also present in the suggestions and priorities provided for service and work life improvement, though organisational specific responses were more noticeable in the improvement questions. Some indications or part explanations for the lack of progress in implementing ICPs as a means for greater coordination in the care for patients were provided in the, at times, seemingly paradoxical stances and organisational locations of staff groups. For example, across all three questions doctors in both Trusts highlighted the need to improve the internal organisation of work yet their responses to questions about culture and reform values showed that they held the most highly individualistic conceptions of clinical work. Further doctors showed themselves to be plentiful in critical comments yet were frequently unwilling to trust and collaborate with others in order to find a solution. Other groups e.g. the nurse managers and the allied health professionals, who were mostly supportive of collaborative approaches to clinical work, believed themselves as being relatively powerless to affect change.

The results indicate that the start of the CMD project, its objectives and goals for the changing organisation of work within and across health economies, introducing multidisciplinary and patient focused approached to care management, were more probably in tune with staff's stated values in NTH compared to CHT. These results also suggest possible explanations for why, by the end of the project, ICPs and more integrated working across the health economy were more embedded in CHT than they were in NTH.

The answers lie, in part, in the greater willingness of managers in CHFT to acknowledge their own weaknesses and empower other groups, especially the medical profession, to work collaboratively. Despite doubts about management's capacity to

effect change and some highly negative outlooks amongst nurses, most staff groups in CHFT were reasonably positive about the possibilities for service improvement and consistently provided innovative and systems-aware suggestions for improvement. In NTH, in contrast, despite some suggestions for innovative, even sweeping change, the tenor of comments by staff suggested a pattern of fear and blame shifting amongst staff, including general managers who appeared to lack creative ideas for change and wanted to disempower clinicians.

Chapter Ten

Emergent Themes in the Interview Data

Introduction

Previous chapters have shown that historical, policy and sub-cultural factors work to fragment activities within hospitals and across the NHS to the detriment of patients' experience and the delivery of coordinated care, and that the two study Trusts were not immune to these effects. Yet it was also evident from the outcomes of the Clinical Work Development Project that important differences existed between the Trusts. This chapter provides a thematic review of interview discussions with senior staff in the two Trusts designed to provide insight into the senior managers' perceptions of their organisation and factors affecting their approach to both clinical and wider organisational management.

In summary, at the time the interviews were given, the two Trusts were very different in their focus, strategy, and internal dynamics. Calderdale and Huddersfield NHS Trust's senior managers had clear ideas about the goals and priorities of the Trust over and above the vagaries of Departmental policy, a common understanding of the term "the management of clinical work" and the Trust's strategy for improving this, and consistency in their assessment of the Trust's strengths and impediments in achieving these. There was a clearly identifiable vocabulary in use amongst the senior management with noticeable repetition of 'catch phrases' between interviewees. Each believed they had made significant progress towards achieving their goals and were keen to keep going. In essence the managers conveyed an impression of being clear minded, purposeful and proactive, and enthusiastic.

In contrast, North Tees and Hartlepool NHS Trust's senior managers were more reactive to the agendas of the Department of Health and the politics of the local area. They were just beginning to work towards the development of a clear identity and mission for the Trust. There was a diversity of opinion amongst them about the Trust's strengths, few shared phrasings, and a culture that seemingly reflected the political environment of the local electorate and community.

Taken together, the interviews suggested that leadership context has a significant influence upon the working of Trusts and their wider organisational outcomes. These,

in turn, have a considerable effect upon efforts to change conceptions about how clinical work should be planned and conducted.

Calderdale and Huddersfield NHS Trust

Goals

Five recurring themes were evident in the interviews regarding the goals and purpose of the Trust. These themes were patients' experience, service redesign across the two sites within the Trust and within the wider health community, financial balance, the interrelationships between these, and the integrated governance of activities within these themes. The provision of excellent patient experience was more than just a theme however. It was the overarching goal, motivation and priority within CHFT. Its pre-eminence was evident across a gamut of matters, ranging from the ethos of the organisation as a whole to the interviewees' aspirations for themselves and the Trust. It was the energising force behind staff who the interviewees nominated as people who have made an excellent contribution to both the management of clinical work and the Trust as an organisation. And it was consistent with the CEO's view of the Trusts' goals as being about doing the very best for patients, the people who serve patients, and the local communities. In her words, "When you meet these, everything else falls into place."

This commitment to the pursuit of excellence in patient experience was common to all interviewees, even the finance director (Fin Dir) who saw himself as being somewhat different in his thinking to most other finance directors, "Number one priority for me would be about service quality in our various divisions, and ensuring financial balance at the same time. Third would be national access targets.... I do think I'm a bit more worried about the patients. I say things that actually got the heart of what the finance is about and not really (what people are) looking at me to say...So going back to the example... I was the one saying it makes no sense delaying the patients. Treat the patients anyway and show the PCTS what they're doing, and then we'll get the money in April anyway..."

Other goals and objectives discussed by interviewees were more specific to their role and specific responsibilities, examples included development of an integrated service strategy across Trust sites, attaining Foundation Trust status, achieving the 18 week waiting time from diagnosis to surgery within the Trust and other national access targets, better management of supply chains and inventory, an examination of HRG costings, and pursuit of improved clinical information provision. However all the interviewees discussed, at some point of the interview, the need for organisational planning and accountability systems to recognise, account for, and integrate the interconnection between clinical and resource dimensions of care.

These other objectives however were almost always discussed within the context of the primary themes and were usually seen as either expressions of the principal goals or a means to achieve these. For instance, in response to a question about whether she would change the emphasis upon the achievement of an 18 week waiting time target from diagnosis to surgery and similar externally sourced targets, the clinical governance manager said she would not "as long as people understand the priorities within them – that they are frameworks for delivering other business that need(s) to be delivered". She went on to say that "there's always the worry when we've got centrally led priorities... that people become so wrapped up in delivering against them. Then (our response) is around, 'Wouldn't we be doing that anyway because aren't we an organisation that looks to deliver excellent services?' ... because that's what we do around here and that's our culture and that's what the organisation is about. As long as people don't just speak about an 18 week target, they talk about ...delivering a service..."

The organisational development director (OD Dir) discussed using the Foundation Trust initiative to drive improvements in patient experience through various initiatives designed to make the patients' experience and organisational costs more immediately relevant to the staff. To this end she had instituted 'mystery shoppers' (patients who were selected to provide staff with immediate 'customer feedback' at the end of their treatment), staff role plays e.g. sitting staff in an A&E waiting room for more than four hours with a leg in a temporary brace and wearing something to impair their capacity

for self-help e.g. spectacles to distort vision, and detailed performance data provision on such things as wait times, complaints received, costs of the alternative treatment plans, service design alternatives etc.

Interviewees were aware of these and numerous other activities in pursuit of the Trust goals. These included:

- An evaluation of the independent sector provision and its potential market,
- The introduction of new technologies and with that service redesign e.g. moving hysteroscopy from inpatient to day case to outpatient procedure over 18 months,
- Redesign of cancer services,
- Improvement of A&E access via the introduction of an medical assessment unit,
- Various work on implementing the modernisation agency's ten high impact changes through service mapping, integrated care pathway development, revision of elective and emergency surgery, examination of follow-up rates for appointments and outpatient clinic routines,
- Investigation of lean methodology, and
- Establishment of locality-based groups to develop a 'year of care' approach to pathways for long term conditions.

Much of this work conceptually and practically linked across several strategies, for example, the work on appropriate delivery modes for long term conditions was linked to the 18 week wait target and work on appropriate diagnostic technology and service redesign.

The Management of Clinical Work

At core, all these initiatives were linked conceptually firstly by a common understanding of the meaning of the term "the management of clinical work" and its functionality in achieving the improved patient care and experience outlined above and secondly by an explicit policy of pursuing the systematisation of healthcare in ways that deliberately

integrated service redesign, efficiency concerns, and accountability structures via integrated pathways.

The senior management were unanimous in their presentation of the management of clinical work as being effective operational management. "Managing clinical work to me means precisely that, you know, managing it in a very controlled and clear way in which we understand the processes and the system in which that's delivered ... it's definitely 'product' management .... (but) we don't like that word here"[ICP Lead], "Managing the clinical process. So what are the inputs that make up the process...in terms of managing them - what is appropriate and timely and prioritised"[DoN]. "As a consultant it's about making the best use of the resources you have for patient care, managing staff, clinical time, operating theatres; as a manager it's managing the working practices of consultants, directing, leading and influencing other people to achieve clinical care of the patient"[Med Dir]. The CEO agreed: clinical management was about clinical systems and processes, "Having the right things in the right place at the right time doing the right things".

Each interviewee agreed with the strategies being used to implement such clinical management systems. They were also generally agreed about what more needed to be done to institutionalise these within the Trust and were determined to use external imperatives as 'levers', 'incentives' and 'tools' for achieving what the Trust had already decided to do. The necessity to achieve various government targets ensured 'bite' and the 'hard edge' needed to obtain 'buy in' from people who'd always thought of pathways as "soft and fluffy"[OD Dir]. "There has to be the 18 week so we're using that as the organisational driver for prioritising the process redesign and the effectiveness and the efficiency work, but we are pulling it together hopefully and we are doing it through pathways"[ICP Lead]. Pathways were also being used as a means to develop another strand of work relating to external imperatives: integrating contestability, patient choice and the Payment by Results tariffs in pursuit of an integrated accountability, quality and governance arrangement framework. Furthermore, workshops and training programmes to deepen staff's understanding of ICP variation measurement and analysis were widespread, clinical champions were given divisional projects to

implement pathways or facets of work associated with pathways, recently 'converted' staff were encouraged to utilise their skills and enthusiasm in communication and training roles, and more informed decision making was being pursued through improved data provision.

The CEO was intending to increase the extent of systematisation in the management of clinical work and was actively seeking to remove impediments, "For that we need some more robust data and hopefully we'll have more activity data that we can utilise and its then around you know, taking models that exist elsewhere and applying them locally. I just don't think we are systematised in terms of how we address some of our clinical processes and we let personalities get in the way."

Externally, the Trust was seeking to harness the commissioning power of the PCTs to drive service redesign, change service delivery modes, 'naturalise' process management of care and change governance structures. At the time of interviews it was seeking to add further weight to these efforts by reorganising the previous Clinical Work Development Project steering group into a locality Board with responsibility for developing and overseeing a health community wide framework for pathways development.

This approach and strategy is consistent with the CEO's elucidation of the Trust goals and method as she saw them. From her perspective the three goals of the Trust were to put patients at the heart of services (via modernisation and pathways), to look after staff (via OD work and other investments in staff) and to look after the local communities of which the Trust is part (through demonstrated effort and commitment to corporate and social responsibilities). In her words, 'deliver on those and you deliver all the rest'.

When asked whether there were things that could be done to further pursue the Trust's goals but which weren't being done, all bar one interviewee suggested that the current processes and strategies be pursued more intentionally and to a greater depth (although there was recognition from two interviewees that "what can be done with the

available resources is being done). For example, the Director of Nursing thought that the Trust should be more systematic in approach and challenge clinical processes more especially in changing traditional working practices in elective surgical activity to drive greater efficiency, "Once a strong challenge had been made, the senior management should make sure that the challenge is followed up and momentum isn't lost by pursuing performance reviews, asking what's happening and, if something isn't working, asking what staff members what they are going to do as an alternative." The medical director believed the Trust executive needed to be more vocal in making the arguments externally in support of this strategy and method, telling the government to "back off", providing a service provider's perspective in the papers and thereby ensuring operational understanding becomes part of the local and national debates about the NHS. For the clinical governance manager it was introducing clinical improvement methodology into the pathways as an operational norm. (When introducing pathways they had limited the conceptual and practice changes around pathways to what were necessary to get clinicians on board but she believed they now needed to expand this.) "We're getting there with it... We've got a huge investment in the Trust in leadership and organisational development support...What you then create is that culture in which the whole lot of strategy in a number of areas comes together." And for the finance director it was "Work(ing) better with the commissioners. I'd be very embarrassed if members of the public sat and watched debates and meetings and things. Members of the public don't care if you work for the Trust or the PCT or whatever, you work for the health service, you are supposed to be making the services better as a whole... we suffer because of our relationships."

Trust's Strengths

The interview questions sought enlightenment on the Trust's strengths in pursuing change in the way that clinical work was managed in the Trust through a variety of questions, some direct and some seemingly 'left field'. Again however the interviewees were remarkably consistent in their perspectives, understandings and interpretations of the Trust and its operations.

Overall Strengths

The Trust's overall strengths in achieving its goals were characterised as being its staff, leadership, 'organisational architecture', and culture. Though some interviewees described these as independent factors, most interviews recognised them as being largely interdependent.

Staff

Each interviewee was asked to think about specific people within the Trust that the interviewees thought had contributed to a successful clinical management activity within the Trust. The selected individuals included clinical staff, clinical managers and general managers, including the CEO. Each interviewee was then asked about the personal attributes of the selected individual and also of people at various levels of organisational support, the immediate team, divisional and senior management levels (when distinct) that facilitated and contributed to the individual's achievement.

The selected staff were described as usually quite charismatic individuals with a real determination to see things through; personally able to make, and take, a lot of challenge; having a high degree of integrity; able to negotiate, with an ability to influence; persistent and resilient; able to lead strategically and operationally; and to bring experience to bear in developing strategy. They were motivated by a fundamental desire or passion to make things better for patients or the health service.

The qualities of the teams and the people in the immediate teams that most contributed to the selected individual's success were described as: having a common goal and world view, strong relationships and joint working supported by good facilitation skills and cooperation, a willingness to challenge and to invite healthy challenge and allowing individuals time to pursue their chosen project.

Similar qualities were listed for those at divisional and senior management levels with the addition of the facilitating influences of the leadership by the CEO and others throughout the upper echelons of the Trust and the coherency between the organisational architecture of the Trust's devolved structure and support processes.

Leadership

Leadership at all organisational levels was referred to extensively by all the interviewees as being a key strength of the Trust. The emphasis upon, and development of, this strength was attributed by three interviewees to the CEO. During her interview, the CEO discussed her leadership approach in considerable detail. She began describing her role as being "around system leadership. I don't manage the business of the Trust, I manage the culture." She elaborated that she saw her role as being the organisational look out, scanning the horizon, warning, shepherding, and advising of what lay ahead though it was the role of others to (jointly) develop and implement strategy to successfully navigate the choppy NHS waters, " You need the vision within all of that, the ability to scan the environment, to interpret the environment, then translate that into what are the right tactical and strategic responses for the organisation and then there is how you then describe that in a way that is meaningful both to your organisation but also about how you describe those changes to the community when that's, you know, quite a difficult thing for them to do when actually they are technically losing services or they perceive that they are losing services... I think there is the need for strategic leadership, you need a strong clinical leadership within all of that in terms of the clinical team."

She described a distributed leadership system (Gronn 2002, Mintzberg 1999,) that harmonised with her personality and values. "I believe you need strong leaders at every level. But you need leaders who speak with a common voice, who are all signed up to the direction of travel, who are all signed up to how that journey will be made in terms of the values and behaviours that are needed to make that journey a successful one. I do believe that people lead by example within organisations and so I'd go for the distributed model. I do though think that there is something about, I do believe that organisations, the most successful ones that I have seen and I speak from experience, not through what I have read in books, but I do think that the most successful organisations tend to be an extension of the Chief Executives personality.... I do think there is something you generate through your own behaviour as a CEO and it goes with the territory you know, the feel of your organisation and you set the standards, you set the behavioural standards. In a distributed leadership model others will pick the ball

up and run with it and I don't believe you can lead these large organisations from the top unless you have competent effective leadership at every level."

Thus, although every interviewee commented on the importance of the CEO whether as a visionary, as being influential in attracting and keeping staff, in providing stability (the CEO had been in place at that time for the four years in the amalgamated Trust and had been CEO of one of the constituent Trusts for the four years previous to that and stated she had no intention of moving on), as significant in determining the structure and processes of the Trust, and as someone who inspired loyalty and trust, she described herself (and others reiterated) as being relatively low profile within the Trust, "My visibility in an organisation like this is minimal, you know, because I am expected to do community leadership. I am expected to do system leadership. I don't, as I have said before, I don't run this organisation, I tweak it."

The transmission of goals, beliefs and values, and the strategies, structures and processes that would achieve those, were the responsibility of her executive team and the teams for which they, in turn, were responsible etc. This strategy was, as described above, to focus upon improving the experience of the entire care process for all concerned within an appropriately supportive structure and culture.

Organisational Architecture and Processes

As noted in Chapter Six the Trust is structured into five divisions, four of which are structured along clinical directorate lines. Its is a highly devolved structure in which support functions such as finance and clinical governance, traditionally organised in individual departments, are placed as close as possible to the clinicians whom they are supporting. Thus business managers, IT specialists and others become part of the 'team' managing the overall clinical work. In the words of the finance director, "We are devolved in everything we do here a devolved organisational structure. But for the finance department, we are a central team here and then we have a team of finance staff out in each of the divisions. So the surgical division will have their own assistant director of finance as part of the team in each division. So where there is work around you know, changing care pathways so that the ISS integrated services strategy works,

where clinicians have fitted into clinical networks and doing work around there, depending of which area and who it is, you know, changing the care around long term conditions, it will be for the finance staff who work it. Medical division looks after their own specialities. Finance people get involved in the process whereby they are changing the pathway. They are looking at where the costs are going to change and then look at the same work: is it more efficient? less efficient? Whether we need to free up resources to invest or not etc." Thus in Calderdale and Huddersfield Trust the traditional functional silos discussed in Chapter Four have been eroded.

The OD director attributed some of the devolved structures and more integrated working practices between the clinicians and general mangers to Department of Health initiatives twenty years earlier, though she acknowledged this was somewhat of a two edged sword. "When the first sort of clinical audit formed, that was cool. I think that started it.... That taught about clinicians in management, didn't it? It moved away from the sort of usual stuff in general management and very much put doctors at the heart of management. We were a pilot site for the Resource Management Initiative, as I've told you before, and I think we've been building on that really ever since, to be honest. ... It went really well for a least a year but it started to peter out because the technology wasn't as good as it is now and we couldn't get the clinical performance information they wanted when they needed it, and they got frustrated and disillusioned. ... I try to get them that passion again but it's difficult when they've gotten so 'What's the point? They always screw you in the end.' So it's important that we don't let this go and not see it through. But they also know that I won't be going anywhere else so..."

Culture

Culture is a symbolic concept that encompasses a synthesis of 'characteristic ideology, language, dress codes, behaviour patterns, signs of status and authority, modes of deference and misbehaviour, rituals, myths and stories, prevailing beliefs, values, and unspoken assumptions' of a group (Scott, Manion, Davies, and Marshall 2003), p1). The Trust's culture was described as "an enabling culture that is more open and transparent, where people want to give, a culture that has attracted good staff, created friends out there in the system" [CEO], a culture of "achievement" [DoN]; of initiative,

experimentation and permission, "freedom to experiment, developmental, the whole approach"[ICP Lead]; and "(emotional) maturity.... can handle dilemmas and difficulties without falling out all the time" [OD Dir].

This was encapsulated within the advice the interviewees said they would give to their nephews and nieces if they were to join the organisation, particularly the advice to work hard, use their initiative and not to be afraid to challenge and be challenged. With the exception of the CEO (who would advise that new staff members should "Smile a lot. Don't argue, just listen"), the majority of the other interviewees gave advice along these lines, "Do your job and do it well, never be frightened to ask for support. If you have an idea share it, don't be afraid to take it forward, Just go for it really, don't wait for opportunities to come to you, you can ask for it here" [ICP Lead], "Put your head above the parapet, take risks, do more than expected of you, look to how you can help other people achieve their goals" [OD Dir] and "Be open to new ideas and challenge the status quo" [DoN].

It was also evident in the common language, particularly the catch phrases, used by the interviewees. Common terms peppering the interviews included 'patients', 'passion', 'systematisation', 'pathways', 'integration', 'leadership', 'think out of the box', 'have a go', 'don't ask for permission, ask for forgiveness', 'loyalty', 'respect', 'integrity', and 'challenge'.

Perhaps it is not surprising then that all the senior staff agreed they liked their jobs and the people they worked with and that, for some, this was intense, "It's very forward thinking, it's supportive and it's got a fantastic culture. I feel like it fits like a glove, it's a very comfortable place to be, it fits my personality. Very, open supportive...some people wouldn't like it. ...I have fantastic job in a fantastic organisation, it lets me expand my role portfolio... this organisation lets you be whatever, within reason, it develops you' [ICP Lead], "I work for this Trust because I am passionate about it" [CEO] and "Its the best place I can make a contribution to the people of Calderdale and Huddersfield" [OD Dir].

Impediments to Trust's Goals

Despite this enthusiasm for the organisation, the work that it does and their roles within it, the senior managers were clear eyed, very aware of the difficulties and impediments the Trust faced in pursuing its goals. These impediments were seen to be sourced in three key areas, the Trust's external environment, its own Trust's strengths and its past. Specific external hindrances were, "Politicians who don't understand service issues [Med Dir]", the pace at which changed is imposed from central authorities and the impact that has on relationships between organisations, "I don't think it's the pace of how it happens because we can respond to pace really quickly; it's the confusion of the reforms that it creates in our partner organisations, I think.... and then our ability to adjust the relationship" and, along with that, the antagonism of the communities to service change, "We spent a lot of effort merging the Trust internally but didn't put the same effort into bringing the local communities along with it" [OD Dir]

Although the CEO saw the Trust's culture as being a strong facilitating factor in meeting its goals, she also acknowledged that it had its difficulties, "I think that the biggest thing is around the hearts and minds job. I think at the moment it's keeping a positive attitude within the NHS. I mean the NHS is in complete chaos at the moment and you know, it is like a rudderless ship, big gaps in leadership at every level, there is no leadership at the top at the moment you know, in terms of the Department of Health, it's chaotic and all the anchor points of the system have gone so therefore the issue for us is about how we keep this organisation on track in a system that doesn't know where its going? ...It's not the negative aspect of the (Trust organisational) culture itself. I think its ability to respond to how the NHS is changing is changing at the moment. Because what is being valued is not what we articulate and so that's going to be interesting for us. Because on a very practical level, the people get in the way. It's the people, everything else is just window dressing."

This was also the concern of the OD director though she expressed it differently. For her the 'problem' of the Trust culture manifested in the struggle to meet "Foundation Trust requirements without destroying something, without redundancies...we're an evolutionary place, not a revolutionary place... that will knock us, if we have to do

something like that". As noted earlier, the OD director was also concerned not to repeat the failure of the 1989 efforts to empower clinicians in taking on traditional management practices. She noted that a repetition of doctors' previous disillusion around the design and costing of their own services would have dire consequences for future efforts to engage clinicians in the integration of managerial and clinical functions within the Trust.

Although the ICP lead didn't think "any of the historical or external stuff will stop it happening because they're happy to wade through some of those traditional impediments", the Director of Nursing was very concerned. "I think there is something about the way we have worked in terms of our structure. It's very much in business units, in essence, and although we describe some cross cutting work that actually follows the patients rather than the business unit, the business unit is stronger than the cross cutting work. I think we are, I think at this point in time, that we are starting to redress that balance but at the moment it is still a very strong link, almost the silo business unit.... One of the reasons I think the business units are so strong is that money is delivered via that route and I think there is some potential (for countering this by) putting monies into networks and managing the resource differently and I think that would strengthen some areas... Payment by Results is going to strengthen those units, that delivery of the money in that way I think." She was also concerned that "some professional groups have been much, much stronger around traditional practices than others. ... I think some groups have been forgotten because they are not in the front line, for example Laboratory staff and things like that and therefore many of their practices have been embedded and not been challenged." She was especially concerned that management and staff did not become complacent about their successes thus far but pressed on persistently towards their goals.

North Tees and Hartlepool NHS Trust

Goals

The NTH interviewees did not convey a sense of the Trust setting goals independently of the prevailing policy paradigm; rather their responses indicated a more reactive approach to goal and priority setting. Fundamentally, all interviewees defined and

prioritised the goals of the Trust in accordance within the prevailing Department of Health priorities, describing the Trust as doing 'what it was told'. Prior to the change in the Department's stance most interviewees saw achieving activity targets as the Trust's first goal and priority. However by the time of the interviews, all interviewees saw financial balance as being the primary concern of the Department and the primary goal of the Trust. They were unanimous that significant pressure to address financial issues as a first priority was being exerted by the Department of Health through the Strategic Health Authority and indirectly through the financial balance requisite for both Foundation Trust status and strong Healthcare Commission ratings. Some staff also suggested that the Healthcare Commission and the Foundation Trust processes further contributed to the separation of financial and clinical aspects of hospitals performance and the secondary priority given to strategy and service redesign within the Trust.

Senior staff were divided about the impact of this goal prioritisation. The CEO was very clear that attaining financial balance was of a different order to corporate strategic function, "Aside from that (finances and quality health care), we move into a different object because the next major objective is that we actually have a clear view of how we develop our services going forward.... I'm very comfortable, I think, with priorities which say that we run an organisation that is in a financially balanced position..." The Deputy CEO/Director of Nursing appeared to accept this stating, "the prime drivers are financial recovery, unfortunately because we'd like them to be something else (laughs), like enhancement, but...".

The priority given to finances was felt in all areas of the Trust primarily through the stringent vacancy freeze which had led to several new initiatives, financially led service redesign, centralised waiting list controls, and a significant focus upon redesigning the nursing function (as this was the largest single cost item in the Trust budget). There was, at times, a grudging agreement that some of this had been effective in identifying better management of clinical product turning net product losses to net profits (in spinal surgery for example), eliminating wasteful practices, particularly in the use of nursing resource, and streamlining specialist services (again in nursing) however there was also a concern that redesign efforts generally, and especially in ITU and HDU, were

either missing important opportunities for service improvement or were threatening the quality of care. There was a common acknowledgement that "in some ways, again, the main motive behind these is really financial or not reaching targets, rather than genuine...looking at the service objectively and saying lets improve conditions. In fact, to some degree, the things we were doing on that basis have been put on hold while people are diverted into meeting (other) priorities" Former Med Dir

Several staff members were keen to see operational and strategic aspects of the Trust considered simultaneously through a coherent 'product based' strategic approach. They expressed concern that the importance of this was being overlooked and suspected that financial primacy would impede the achievement or scope of other goals. "I can't rate first three listed as hierarchy because they are simultaneous goals. First priority for achieving these goals is understanding the whole care process – we can't achieve the others without this. At the moment the emphasis is on financial balance by cutting posts, but not necessarily in the right places.... You can't look at the organisation as if it has a life of its own, independent of those products. If we want to be leaner and slicker, we have to be leaner and slicker in doing those product processes. We cannot do it simply by having less staff doing the same processes or cheaper staff doing the same processes" OD Dir. "In an ideal world the Trust priorities should be to provide the best clinical services in the best configuration. ... Ideally what we want to do is rationalise our services, increase the efficiency and reduce our costs. I think that should, you know in an ideal world, that's what I would like to see happening"Former Med Dir "I think it has to be strategy, it's about getting corporate vision and taking all of the key stakeholders in the same direction that we want to take this Trust. The Trust needs to be commercially run, it's the way that the pay reforms are leading us and really we have to try and put in the tools and techniques. I think clinical service development around innovative ways of providing patient care is in there as well...we've been challenged by other issues that have taken our eye off what we are here to do, if that makes sense" IMT Dir "The best value group– their priority should be service redesign necessary to improve quality of patient care and delivery of that. However they are doing it the opposite way around - how can we save money? What can we redesign to save money? And then they say, 'Right, I'll come and redesign that

to save that money.' It's like everything else, they do everything else back side round" ICP Lead

Both the financial and service design pressures were exacerbated by the imperative to implement the Darzi service review, widely regarded amongst senior staff as a blatant piece of electioneering imposed without proper regard for the financial and clinical implications for the Trust and its local communities. Several interviewees commented on the negative impact of this review, "The Chief Executive has said that finance is the top priority, but we've got Darzi, which is being imposed upon us, which works against that priority because a lot of the things we want to do to achieve financial balance, like centralising services, Darzi stops us doing"OD Dir and "We are producing a lot of things twice, you know you're buying two lots of x-ray machines, two lots of theatre kits, we're paying for two lots of junior doctors rota's, we're running a full emergency service on both sites where we could have one site emergency. We could save many millions of pounds.... instead of the review's outcome being based purely on clinical service grounds, a lot of it is bitten into by politics which go against the logic of clinical service. Unfortunately I think that some of the gains we could have got we'll lose because of political interference" Former Med Dir

The interviewees' personal goals reflected their desires for the organisation's goals, amongst other things. Whilst the CEO was upbeat about the hospital being the best run and the best deliverers in their local area, others were aware of the difficulties in getting there, "to achieve the necessary financial balance with minimal disruption. I think that, I wouldn't say that they were fire fighting, but it's definitely an organisation for fighting fires at the moment" Deputy CEO/DoN. The OD director wanted "to get absolute clarity about who's responsible for managing clinical care. I'm not really bothered about what the decision is, as long as we have that clarity." The former medical director was concerned to "bring up the quality, I don't think we work with maximum efficiency and effectiveness and I would like us to do that". There were also some personal goals that were much related to the interviewees' professional niche. For example, the ICP Lead wanted to complete the variance analysis database, the deputy CEO also Director of Nursing) wanted to raise the profile and influence of the nursing profession and the

Director for Information Management and Technology wanted to see the full implementation of an electronic care record.

Trust's Strengths

Interestingly, there was little, if any, coherency between the interviewees about the Trust's strengths for meeting these organisational and personal goals. The CEO suggested these lay in the Trust's clinical strengths, clinical governance mechanisms, and its reputation for both of these within health and amongst the community. This seemed somewhat odd as it is not obvious that the local community had a good understanding of the Trust's clinical governance mechanisms and their relevance and no evidence for this assertion was provided. The Deputy CEO (also the director of nursing and clinical governance) thought it was the 'clinical buy-in' and 'the propensity to change (that) is there because people are willing to change' – something which other interviewees thought was missing, and which even he said he thought was lessening due to the central control associated with the financial regime.

The former medical director believed the Trust's strength was the stability and loyalty of the workforce from the local area though he admitted this did not apply to doctors. The IMT director thought it was the strong leadership and good alliance between executive and clinical directors, although the ICP lead and others spoke of the difficulty in getting clinical directors to provide leadership, particularly amongst doctors. The pathways coordinator thought the Trust was "forward thinking and it does try, and it tries to make it multi-disciplinary, like, everybody has an opinion, it's not hierarchical" despite also saying that she didn't know anything about a strategic plan. The organisational development director, with perhaps greater realism about the Trust's position at that time and honesty about his own uncertainty about its operational direction, suggested it may be the fact that, at that time, the Trust was "facing collapse. I think survival is a great motivator. We have a new chief exec, we have a new chairman, we've got a new director of acute services and we're about to have a new director of finance so more than half of the exec team has changed. We've got a new medical director as well. So I think that in itself prepares the organisation; it's not just going to carry on... (the

situation) is forcing people to focus on our efficiency and clinical care and if it's costing us more, we have to do something."

The Management of Clinical Work

In the light of the above it was not surprising that, although there was a common agreement within the Trust about what was meant by the term 'managing clinical work', there was less agreement about what was required to achieve it. All interviewees, in greater or lesser detail, observed that managing clinical work meant insuring that the activities of clinicians deliver quality care for patients and delivering the organisation's objectives. However, unlike CHFT, there were few suggestions about how this might be taken forward in NTH.

Several staff believed that achieving effective management of clinical work required adopting new, more appropriate management structures and processes. For the OD director managing clinical work was about "managing what happens to a patient who's coming in, going out, that whole journey, not just specific elements of it. Not somebody managing the outpatient elements and somebody managing the nursing element and somebody managing the therapists and somebody else managing the doctors. It's just, whatever the condition is, it's managing it right across... which necessitates a matrix type organisation. You can't do it any other way." And he believed that 'Nobody is managing that'. The ICP lead likewise believed that effective clinical management required "having structure so that we know what we are doing is what we're supposed to be doing, what's expected of us, and ensuring that we have continuity, and I think that's what pathways gives.... That means having a clinical management structure for *everybody* with whom you work, not just yourself." These beliefs however ran directly counter to the CEO's belief that clinical management required "a framework within which individuals should largely be atomised and self managed unless they step out of line, in which case they should be helped to get back on line for appraisal of necessary management."

Identified Impediments to Trust's Goals

There was agreement, though not unanimity, between senior management about the impediments the Trust faced in meeting its goals. These were identified as, firstly, internal problems with clinical engagement and, secondly, the processes of various external bodies and machinations by the local politicians, especially in regard to repeated and protracted service reviews. Problems around clinical engagement were expounded upon, often at length, by all but the CEO. These expositions revealed that clinical disengagement was both long standing and multiple rooted. Some roots are located in the nature and history of the wider NHS; others however were associated with previous Trust management practices.

Front line staff were believed to be unable to see the bigger picture or to think out of their own box, doctors (especially consultants) were believed to have insular and entrenched positions as 'artisans' and 'craftsmen' within their own specialties and the wider organisation, and to be resistant to new skill sets and techniques whose introduction would create shifts in power. This was exacerbated by consultants' financial and performance security relative to other staff but also by the fact that staff, especially consultants but not exclusively, had been allowed over time to "get away with doing what they want" ICP Lead & IMT Dir.

Interviewees with a longer history of employment in the Trust believed that the previous history, over many years, of initiatives failing through poor management practices at both strategic and operational levels had had a considerable effect in further entrenching clinical disengagement and resistance. Strategic failures listed by interviewees included failures by the Board to ensure clear role definition between themselves and the senior management and, with that, transparent, consistent decision making; and failure by the previous CEO and the Clinical Policy Board to provide clear leadership, to develop appropriate and consistent strategy, and to both consult with Clinical Directors and ensure that they acted as organisational managers. Poor operational management processes listed included failure to align roles, responsibilities and structures throughout entire the organisation, to provide clear role definition especially for the Clinical Directors, to properly authorise staff tasked with implementing

new initiatives, to ensure that allocated responsibilities were being properly fulfilled, and that underperforming and recalcitrant staff were identified and either encouraged or disciplined.

The new CEO was commended by other senior staff for beginning to address several of these issues through various initiatives. These included being more transparent about decision making, seeking to involve the clinical directors more in decision making, disbanding the Clinical Policy Board and replacing it with a new body (the Trust Directors' Group), and attempting to limit the power of the consultants. The CEO repeatedly emphasised throughout the interview that the Trust was "only just starting" in these initiatives, to develop a strategy, and address the Trust's underlying problems. He was forthright that the Trust had had a history of 'an absence of strategy', still lacked strategic goals and strategies beyond financial balance, and that much more could (and would be) done to address operational problems. Interviewees were concerned however that several key issues were not being addressed and that this was undermining the potential effectiveness of those listed above. Of particular concern were that the Finance Director simply made announcements in the Trust Directors' Group without consultation, that the Clinical Directors were not expressing their disquiet about this, and that their silence in this forum was taken as acceptance. There was also concern that the clinical directors' roles remained vague and uncertain. As a result they were not competently managing their staff and directorates to address the wider organisational implications of clinical work and were avoiding cultivating careful education, consultation and partnership with their staff in these matters. Instead they were tending to impose budget cuts and the vacancy freeze, seemingly without a creditable rationale, thereby counterproductively generating further resentment and resistance. As a result, consultants still did not see that they have an important role to play in influencing and redesigning operational processes to the simultaneous benefit of clinical outcomes, patient experience and financial success.

This resentment towards management was aggravated by what doctors and other staff saw as the false economy and insensitivity of the 'draconian' vacancy freeze and the pettiness of other decisions, for instance, the doubling of the staff parking fees and the

ending of sandwich provision at lunchtime meetings. As a result, consultants and nurses were dismissive of Trust policy decisions and were continuing to make countermanding and unilateral decisions about resources, especially nursing and support staff resources.

Culture

'Delivering' on projects, targets, finance and Trust policy with a 'can do' attitude was the most commonly named value said to be admired in the Trust. Good leadership, vision, clarity of goals, honesty, integrity and teamwork were each mentioned in more than one interview; there was also some recognition that what people valued depended in part on their role and expectations. Front line staff, for example, valued "people who are good clinicians who they admire for their skill. Who provide and can supervise a good clinical service, can motivate the staff and include them in the decision making... as opposed to somebody who's dictatorial who's telling them what to do" Former Med Dir. These were also the characteristics attributed to people named as having made a significant contribution to the management of clinical work. Virtually all named staff were described as being strongly motivated by patient care, able to make conceptual links between ideas, initiatives and practice, identify what they had to do to make change happen, and do that with personal integrity. They were often described as 'forthright', 'passionate', 'can do' people whom others respected for their competency. Unfortunately most interviewees also either commented directly or alluded to an absence of many of these values in the Trust.

Whilst the CEO listed all the above values as important, also including "an ability to relate what you're doing to why you're doing it and how it fits in with the overall purpose of the organisation", he repeatedly admitted that, beyond achieving financial balance, the Trust didn't have a clearly defined purpose. The lack of good leadership and vision ("we don't have too many visionaries" IMT Dir) led to the staff "screaming out for direction and leadership" OD Dir. "There is not a lot of direction given within the Trust ... it's fire fighting. And stumbling around" ICP Lead.

The stumbling around was compounded by the earlier mentioned failure to ensure that responsibilities were being properly fulfilled and that underperforming staff were identified and dealt with. "You're given goals, they don't follow up on them, because then they go off on tangents. There is no follow through and no review. No reflective viewing, what worked and what didn't. As long as you're producing they don't want to know how you're doing it or how you did it, as long as you get from a to b. And they'll give you c, d, e, f and g in the mean time and still expect you to get to b" ICP Lead. She and others gave examples of various staff - nurse managers, clinical directors, consultants, even the medical director – who were not following through on their roles and responsibilities, some of them in open defiance of directives, and who were not being managed in this. The prevalence of this was indirectly confirmed by the CEO who noted that there was an as yet unmet need to "challenge people where they are not meeting those expectations because they either think they aren't important or don't think they need to be accountable".

The pattern of a lack of follow through was attributed in part to an assumption within the Trust that words equal action, 'Because I'd said it, it will happen' and in part to be conscious choice by some, "xxxx's a master at that and I think it's a purposeful strategy for him because I think if he doesn't ask, he doesn't need to do anything about the non achievers. It sounds cynical I know..."OD Dir. It may also be related to staff training in performance appraisals and team/staff management, "There's a lot of lip service to reflection, KPIs, appraisals. I shouldn't say that, but, it's true! Appraisal meetings are, "What have you done? And while you're at it, can you do all this now as well? There's no 'How's it going, what problems are you having, what do you need help with?'" ICP Lead. Indeed, the CEO thought improved programme interviewing was one of the things that could be done to support better clinical management that was not yet being done.

The perception of 'lip service' with it's undertones of dishonesty seemed to be widespread. Senior managers were aware that the Trust staff did not believe that honesty and integrity were values that would be relied upon. "It was microbiology, and they were given the usual spiel....you know, you've got to make these savings, staying the way you are is not an option.....and somebody said 'you know if you're just honest

with us we'll do it' and by and large that's fairly true, I mean staff aren't stupid....No, they all think somehow there's a hidden agenda there, I mean you talk to many of them and you talk to many senior managers and they will not accept that we're in the financial straits that we're in. They'll say things like 'Oh, we hear this every year' and you know they are just virtually lying to make us toe the line and what have you" [OD Dir].

Such comments about lip service and perceived dishonesty could be dismissed as mere semantics or as just typical of the sorts of things that might be said by front line staff confronting the differing priorities and cultures of managerial staff. However the interview evidence suggests that the managers did have a tendency to speak, if not in double speak, then with an equivocality designed to sugar coat/shelter the truth. The CEO's comments about the Trust purpose quoted previously are an example, as are "the role is to achieve the necessary financial balance with minimal disruption. I think that, I wouldn't say that they were fire fighting, but it's definitely an organisation for fighting fires at the moment" [CEO] and "And I don't think we have that – not an overriding strategy. We have lots of little strategies. But I would imagine we have got an over-riding strategy. But if we have, I ain't seen it" [ICP Lead].

From this perspective the CEO's repeated emphasis on 'starting' to address problems (12 times throughout the interview) could be seen as both confronting reality (many initiatives truly were just beginning to address problems) *and* avoiding saying anything about what wasn't done previously, for how long, and why. Such careful and/or convoluted use of words, hiding some things and foregrounding others, is a tactical move used by everyone at times, often for well-intentioned reasons and with good outcome. When used frequently or indiscriminately however the practice can easily be construed as deceptive. In this case, it appears that the Trust executive had, unwittingly or otherwise, adopted as a working norm a practice associated with the external environment of the Trust.

Wider Hindrances

Other interviewees were more explicit about what was not being said by the CEO, attributing paralysis in the Trust to four (apparently interrelated) phenomena. These were the:

- Indecisive leadership style of the previous CEO,
- Repeated and protracted external reviews associated with the political gamesmanship of a previous local member of parliament,
- Highly politicised nature of the local electorates,
- Unresolved cultural differences and resentments between the two hospital sites arising from the amalgamation of the two previous hospital Trusts.

The various reviews to which the Trust had been subjected, especially the often quoted Darzi review, were widely believed to have been initiated outside of due process by the then incumbent local member of parliament for Hartlepool. This parliamentarian had a reputation for 'fixing' things, was a prominent Government minister who left the ministry and Parliament in circumstances which undermined his reputation for probity, and is currently an EU Commissioner. The majority of incumbent electoral representatives in other local electorates were/are also senior ministers or influential figures in the national government. Their pervasive influence and power locally were believed to have created highly parochial approaches to major issues, reinforced by a highly vociferous local press dedicated to preserving local interests. This parochialism could perhaps even be termed 'a siege mentality' - not surprising in an area that had known widespread decline and significant deprivation over many decades. It is perhaps not surprising then that the reviews were regarded internally as blatantly political machinations with a predetermined outcome, not premised upon any underlying clinical or financial reality.

The highly contentious political environment predated the amalgamation of the two predecessor Trusts and contributed to the tensions inherent in the amalgamation. It was always likely to be a difficult amalgamation in that there were fifteen miles between the hospital sites, distinct local differences and rivalries between the two towns (despite

the wider political and economic circumstances), distinct cultures within the hospitals (the Hartlepool hospital was, and is, seen by staff who travel between the two sites as more integral with the community and to be a friendlier, more socially integrated worksite), different work practices between clinical sites, and the Stockton Trust carried a significant deficit into the amalgamation. The financially sound Hartlepool Trust saw itself as being forced to 'bail out' the Stockton Trust to the detriment of its own services and staff. Significant clinical staff in some departments, especially orthopaedics in Stockton, refused to travel between sites (a practice that still continues). The resilient animosity to the amalgamation between significant sections of staff in the two sites appears to have both fed off, and to have added to, the Trust's highly politicised environment.

Most Trust staff were, and are, long term local residents. Senior staff were well aware of the blurred lines of authority between the Trust Executive and Board; were and are required to regularly interact officially at various levels within the community; and have been 'burnt' repeatedly by the (vociferous) local press. It appears that members of the Trust have learnt to play the political game themselves, however wittingly or unwittingly, in order to deal with the external environment's impact on the Trust's strategic and operational matters. This could provide a partial explanation for several troubling aspects of the Trust's culture – the use of obfuscating language, the selective attention to problems and people, the fudged lines of authority, and the lack of independent goal setting behaviours. In this environment it is not surprising that, regardless of her personal style or ability, the previous CEO may have found it difficult to provide decisive leadership. It is also not surprising that this, in turn, was seen by some interviewees as exacerbating the Trust's difficulties with staff resistance.

To some extent these behaviours could be regarded as expected outcomes of the longstanding and unresolved tensions in the wider NHS, the recent history of repeated seismic policy shifts within the Department of Health (discussed in earlier chapters), and the repeated reconfigurations of associated NHS organisations. However the prevalence of these behaviours in NTH staff contrasted with the comparative lack of

them in CHFT, which was operating in the same national policy context and had an outwardly similar organisational history.

The impact of these behaviours was evident in the advice the interviewees said they would give to a nephew or niece starting work in the Trust tomorrow. Several interviewees' first response was that they would tell them to take another job elsewhere. All offered advice that entailed trying to keep clear of the negative aspects of the Trust's culture. This included "Understand what you are here to achieve in terms of your own role. Understand and be able to work with the other professions, teams... Understand the expectations of the organisation as a whole. Whether you should challenge those expectations or go with them"[CEO], "Understand the dynamics of the NHS and the reasons why it's in the position it's in, I think that's critical that you appreciate the history and then look for opportunities to influence change" [IMT Dir] and "Make no assumptions and always check what you're doing is what is needed.... because you'll never be told otherwise" [OD Dir].

Despite the difficulties, the interviewees did believe, as the CEO emphasised, that things were beginning to change. There was recognition amongst senior staff that things couldn't continue as they were; strategic vision and goals are necessary and important and the newer executive staff had brought a fresh way of thinking of things. There was a belief that the emphasis upon pathways and the earlier Clinical Management Development project had increased awareness of the interrelation of effectiveness and efficiency amongst clinical staff, and that the 'saving' of spinal services through an effectiveness and efficiency review was providing a kind of spearhead for entrenching such thinking and practice within the Trust.

Discussion

Three key though subtle issues run through the interview narratives within the Trusts. These are the longevity, 'localness', and style of the CEO and staff and the influence for better or worse these have in achieving change (or not). The CEOs in these Trusts at the time of the Clinical Management Development project differed in expected longevity and style. The contrasting sense of stability that one 'felt' rather than

'evidenced' in the interviews in the two Trusts was palpable - and consistent with impressions gained during the conduct of the Clinical Management Development project.

In a period of relative turmoil within the wider NHS, the CHFT's CEO's intention to be there for the long haul despite the pressures in the NHS system, and the sense of stability this has engendered amongst staff, appears to have provided staff with a buoyancy and optimism. This buoyancy is complimented by the long term employment history and expected continued longevity of key senior staff such as the Organisational Development Director. As the OD Director noted on several occasions during the CMD project and throughout the interview, "They (the doctors) know they can't wait me out and they know they can't pull the wool over my eyes; I've been through the same pains they have and I'm not going anyway".

The expected longevity of the then current NTH CEO was not mentioned in interviews, either by himself or by others. This was perhaps an important omission. His personal background indicated someone who has changed career directions and positions relatively frequently. His conversation was peppered with 'We are starting to...". In discussion about why he worked for the Trust he answered that he was attracted by the challenge and the risk, adding that "Well if the worse comes to the worst, you do something else, don't you?" In itself, this demonstrates personal courage, resilience and an acknowledgement that not everything goes to plan. However from the perspective of the acknowledged need to achieve sustained change during a period of turbulence, any suspicion or belief by staff that the CEO is only in it for the short term, could undermine the very thing he, and other Trust staff, were striving for. The need to feel secure in the long term direction of the Trust also appears to be important in achieving the support and participation of staff, particularly to long term NTH staff who have seen repeated failures to complete flagship initiatives.

The issues of longevity of staff, localness of knowledge, and freshness of vision introduce a need for careful judgment in selecting new staff. It appears essential that a Trust balances active local recruitment and retention with attracting people from non-

local and non-NHS backgrounds into strategic and operational positions. The CEO in CHFT has created a community development post and staffed it with a (locally born) senior staff member who has proven herself adept at seizing new investment opportunities and dealing with politically difficult situations. She also supported some staff (the finance director for example) working in commercial, non-health fields for short periods of time (up to two years). CHFT also appears anecdotally to have had relative success in attracting staff from outside the region. The introduction of new ideas associated with these processes is perhaps more important than initially may be recognised. Change needs to be envisioned before it can be pursued. Habits of thought and deed need to be broken and new ones established but with careful regard for the histories of previous success and failure.

NTH senior managers recognised that, apart from doctors, they have had difficulty in recruiting and retaining staff from outside the region; and they do not practice 'contracting out' staff for training elsewhere. (Even the new CEO was not 'new' in the sense that he had had previous role in the region and one of the predecessor Trusts.) These weaknesses appear to have impeded the Trust's ability to innovate and think strategically in difficult circumstances. Nor do the Trusts managers actively promote community engagement roles to creatively manage the pervasive politicking, parochialism and passion in the local community. These differences in the two study Trusts in managing change suggest that the need to have a thorough understanding of the local conditions and Trust's history (including previous failures) has to be held in tandem with the need for freshness in perspective and ideas if a Trust is to overcome a legacy of distrust and create a positive dynamic amongst its staff.

The style of leadership appears to be important in balancing these tensions and dynamics. The CHFT CEO presents herself and her management team as inclusive, approachable, far sighted, clear minded, reasonable and stable. Her style is to ensure any tension or conflict is cognitive, based around ideas of what could and should be done to promote the long term benefit of the Trust. She sees herself as being mostly a 'horizon scanner', looking out for what's about to come over the hill, and strategising how to use it to further Trust goals or to minimise its destabilising potential. She trusts

her staff to do their jobs well and encourages innovation, managing the additional risks by holding people to account for their progress towards goals, supporting them in difficulties, and rewarding success. All senior staff appeared to expect to submit regularly to 'reasonable' review; this was viewed as being both fair and advantageous for themselves, their credibility, and the wider Trust. This contrasted with the sense of unpredictability and inconsistent accountability, and the attendant defensiveness and demoralisation, that seemed a part of life in NTH.

These findings imply that efforts to change an organisation's clinical work practices, and the organisation and management of these, cannot be divorced from the wider management of a healthcare organisation. This, in turn, cannot be divorced from either the specifics of the internal dynamics of the organisation or its local community context. Despite outward similarities in the histories and policy contexts of the two study Trusts (see earlier chapters), local factors had significant impacts. The most important of these appeared to be the clarity of vision within the organisation about its purpose, goals, strategies and strengths; awareness and care in managing the local political environment; corporate ability to be purposeful and disciplined in pursing these goals; and leadership wisdom in balancing stability with innovation, and 'localness' and longevity with freshness and energy.

Chapter Eleven

Conclusions

Raison d'être

This thesis' genesis lies in the inconvenience and frustration often experienced by recurrent users of health services, especially families with intellectually disabled members. Its foundational themes emerged from the difficulties encountered by the author when working with service providers to restructure clinical work and to implement more organised, multidisciplinary approaches to care management. The need to understand the impact contextual factors have, both in sustaining the status quo and in supporting the institution of new ideas and practices, provided the motivation and momentum for its undertaking. Recognising that studying the coordination of care within and across the related sectors of health, social care and education was an enormous undertaking, I narrowed my focus and more tightly defined my research question. Strategic and logistic considerations (i.e. what could make a real contribution to knowledge and be manageable within the required time frame given my personal circumstances and time availability?) led me to focus upon the coordination of care in one sector and specifically upon ICPs as one example of various putative means for coordinating and delivering care. Thus my thesis comprises an examination of the differing contexts and outcomes of efforts to institutionalise ICPs for organising and coordinating clinical work in two Trusts in Yorkshire and northeast England.

This chapter draws the emergent themes and findings of this investigation together, discusses how the research could have been improved, and suggests where further research may fruitfully be undertaken.

Final Discussion of Findings

Reviews of Wider Contexts

The Department of Health's role is, broadly speaking, to manage the English health care sector. It does this through a plethora of structures, policies and guidance. Together these activities shape the highly specified operational framework for the NHS as a whole. The Department intervenes in the wider healthcare sector through the manipulation of market structures and/or local health organisations boundaries and roles. It sets the wider operational context through a variety of means, including statutory bodies and governance mechanisms. NICE and NSFs outline national

healthcare priorities and minimum national clinical, safety and technical standards that all NHS organisations are required to meet. The Department endeavours to ensure that these required standards are met through the activities of inspection bodies such as such the Healthcare Commission and Monitor. It also has legislative authority to alter professional organisations, their oversight of healthcare professionals, and professional remuneration rates.

The Department of Health does not, however, specify how clinical work is done at the 'shop floor' level. It has always delegated responsibility for the practice and management of clinical work to the health professionals working locally in provider organisations. As health professionals traditionally were accountable only to their own professional bodies, the organisation and oversight of care in hospitals and other healthcare organisations has been historically characterised by a fragmentation of care activities between the medical, nursing and allied professions. For, although each profession historically self-governed its 'bit' of the care process, no one profession or individual was charged explicitly with the coordination and management of care into a coherent whole. Care responsibility was simultaneously "everyone's and no-one's". Patients, by and large, were and often still are, left to their own initiative in navigating the resulting vagaries of care provision. Some managed well but others were known to fall through the cracks, often creating an even greater need for public service assistance, whether from health or social care or other government functions.

The lack of accountability for overall performance in public sector health care provision began to change with the Thatcher government's drive towards its better economic performance. This government promoted a more managerialist oversight of organisations and sub-units, emphasising hierarchical responsibility and accountability for corporate performance. The incoming Labour government continued the drive for accountability, widening CEOs' accountability within healthcare to include clinical processes and outcomes as well as corporate responsibilities, instituting new mandatory clinical governance mechanisms at local organisational levels. Simultaneously, however, the Labour government also placed heavy emphasis upon newer and more collaborative ways of working. This dual thrust permeated health

policy documents and has been incorporated into inspection bodies' more recent approaches, for instance, in the Healthcare Commission's adoption of more integrated standards. Despite this, the working out within NHS organisations of the changing responsibilities for care processes and their outcomes has been largely left to local discretion. Senior managerial and health professionals are expected to freely exercise their professional skills, expertise, judgement and autonomy in integrating the organisational and clinical dimensions of care to patient and organisational benefit.

This policy of pursuing strong organisational regulation at the executive levels of Trusts whilst upholding relative clinical freedom (and predominantly self-regulation) on the shop floor has, however, created a disjunction between the new Departmental central diktat and established local and professional norms. Such norms and cultures are very difficult to change. People who grow up in only one locality tend to 'become' the community; they are predisposed to accept its assumptions, absorb its values and, in their communal attitudes and activities, enact a distinctive way of doing things. Employing predominantly local staff in NHS organisations, especially in localities that have experienced relatively little influx and social change, therefore embeds local history, outlooks, politics and 'ways of doing things' into a supposedly 'national' organisation. It is virtually impossible to insulate constituent NHS organisations from such local influences; thus 'rollouts' of central policy initiatives are rarely as unproblematic as national governments, and the departments that act in their stead, like to portray.

Moreover, research has shown that the cultures, values and practices within professions are equally resilient to change. Discipline-specific educational, professional socialisation, legislated power differentials, and public expectations all tend to entrench historic, more uni-professional values and arrangements into the organisation and delivery of care. The existing arrangements focus attention on the separate components of care for individual patients, and the practices of the individual professionals who provide those components of care, rather than a collaborative and coordinated approach to meeting the intertwined needs of patients, families and carers.

The final outcomes of national or regional improvement programmes, therefore, are liable to be as dependent upon what is, and what is not, acceptable to the local community as they are upon the intrinsic rationale and coherency of the national policy. For this reason, national rollouts would appear predisposed to producing a geographical medley of relative successes and failures, with successes likely to have somewhat different 'look and feel' between localities.

Research into More Immediate Contexts

This thesis demonstrated that central diktat alone will not achieve more coordinated care for people requiring ongoing care across professions, health sub-sectors and social services. Success is likely to be hard won and will require very careful construction of organisations and composite systems of care sensitive to local conditions and constraints.

The activities of Trusts in and around the Clinical Management Development project provide evidence in support of this. The CMD project was a regional response to the national policy of NHS 'modernisation'; its purpose was the modernisation of the management of clinical work through more collaborative and coordinative processes. Neither CHFT nor NTH have been completely successful in empowering health professionals to work and make decisions collaboratively and in institutionalising collaborative approaches to clinical work, particularly ICPs. The evidence suggests, however, that CHFT is much further down the road to this than is NTH. The evidence also suggests that a multiplicity of factors must be taken into account in constructing an effective change approach, many of which, though not all, are in the control of management. Central here are organisational legacy, environmental context, an agreed understanding of the management of clinical work and how it should be pursued within and across local organisations, and careful designation of strategy and implementation of structures and processes in the light of these.

Organisational legacy is rarely in the control of management, but how senior managers work with that legacy is in their control, and this is probably a more determining factor for future outcomes. CHFT and NTH inherited similar legacies as newly amalgamated

Trusts. Both Trusts had a mixed lineage, both resulted from an unwanted amalgamation, both were comprised of a previously financially encumbered Trust supposedly 'taken over' by a more strongly performing one. Both consequently began operations with replicated facilities, division amongst staff, and resentment and distrust towards management. The Trust managements' handling of these legacies, however, was very different.

The management of CHFT sought to both confront its legacy directly and to support the staff through that process. The CEO and the Trust board set in place an organisational architecture that ensured the Trust would be managed as an integrated entity. They populated senior management with respected staff from both predecessor Trusts, moved them out of their comfort zones, and expected them to work with the 'other' (whether the 'other' were sites or professions). The new senior management team worked assiduously from the start to address the inherited debt problems, to improve clinical performance, and to integrate clinical and organisational activities. Working on the principles of services not sites, devolution, and partnership between clinicians and management, they also worked to understand staff's perceptions of the new arrangements, listen to staffs' concerns about organisational weaknesses, and identify and pursue staffs' hopes and desires for the Trust in the future. They acknowledged staffs' emotions throughout the amalgamation process and accepted responsibility for faults.

In comparison, the process of amalgamation in NTH took a less directive approach. Perhaps in the belief that a gradual pursuit of amalgamated identity and practice would minimise disruption, the new CEO and board adopted structures and stances at amalgamation which effectively signalled that, at least for the interim, the Trust would operate as one in name only. The initial organisational architecture and the pattern of recruitment of staff into senior positions, however, created a sense of 'us and them' within the senior management. Senior management was divided between staff from Hartlepool and staff from North Tees, and between staff with clinical responsibilities and staff without these. The divisions significantly weakened the social and hierarchical authority of the CEO and the executive team, and appear to have engendered a sense

of alienation and instability throughout the Trust. Over time, fewer and fewer clinical staff seemed willing to cooperate with management and fewer and fewer managers seemed able to impel them to do so. Furthermore, fewer managers, whether organisational or clinical, seemed willing to implement standard accountability mechanisms. The motivations for this situation are unclear and may have been multifactorial - a reluctance to cause further tension, the pressure to meet the ambitious Department of Health targets, the consequence of a wider political strategy, or a combination of these. The interlaced effect of the organisational architecture and the stances of staff, however, was a spiralling attenuation of hierarchical and relational authority.

As organisational studies' writers have noted, over time founding CEOs' personal styles tend to fashion each organisation's internal dynamics and emotional climate. The founding NTH CEO's personal style, and the reported repeated reversals in decisions and staff relations that accompanied it, may have cause a diminution of authority in the Trust and created a defensive atmosphere. Additionally, staff based in Hartlepool, who previously had been governed by strong and highly visible leadership, may have become disoriented by the change in leadership style. The perception of a less consistent and less visible leadership probably created a sense of drift and instability within the organisation. Staff were uncertain about what was required at any given time and, anticipating little managerial 'follow through' on new projects and responsibilities, became reluctant to commit to new initiatives.

The influence of the CEO upon each organisation's emotional climate and ethos was also apparent in the differing emotional tones in the two Trusts' survey and interview data. The overall tone of staff's comments, inclinations towards empowering or disempowering staff, a sense (or lack) of hope, and the proffering of suggestions for how things might be done differently within the Trusts, conveyed an almost indefinable sense of lingering presence, almost as if someone wearing distinctive perfume had left the room. Aspects of this infusion of values and approach into an organisation over time were observed in the two Trusts during the CMD project and alluded to by staff during the research. The infusion occurs as staff accept and interact with a CEO's

style, personality and strategic functioning. When the CEO projects a desirable future and confidence in achieving it, staff are apt to look for signs of positive change, be encouraged by indications of progress and success, affirm the CEO and his/her leadership style, replicate associated behaviours and attitudes, and further embed these in the organisational psyche. This is all the more so as staff see the general management 'walking the talk', demonstrating a willingness to make personally costly changes, and accepting responsibility. However, if the CEO is negative and/or blame shifting, a destructive mindset can take hold in the organisation, fuelling demoralisation and self-protection amongst both senior management and staff.

A second important aspect of leadership that emerged from the research was the perceived likely longevity of the CEO. In 2004 a perceived lack of authority and uncertainty in NTH was more apparent, accentuated when the CEO took extended leave shortly around the time of unfavourable reports from external inspection bodies and a restructuring of regional NHS financial mechanisms. The appointment of a new CEO brought hope that the Trust's financial woes could be reversed but some believed this post would be short term and would not lead to substantial change in fundamental facets of the organisation. And, in fact, the Trust culture in this regard remained effectively unchallenged and care practices continued largely unchanged. In contrast, in CFHT staff knew that the CEO and the executive team intended to stay long term, were determined to see significant change in the management of clinical work, and intended the institutionalisation of these changes to spearhead the Trust's long term performance and reputation.

Local political and social dynamics contributed additional qualities to the organisational emotional climates and behavioural characteristics. Staff regarded the two NTH hospitals as being used to further local parliamentarians' ambitions; some staff may have been also using local politicians' desire for greater position to seek professional and site specific advantage. Perhaps in order to survive in this climate of self-interest, some staff had seemingly adopted smoke and mirrors manoeuvres and/or 'spin' approaches to issues that are often associated with national politics. Thus, the negative qualities inherent in local politics and the divisive dynamics created in NTH at

amalgamation appear to have become entangled, creating a sense of powerlessness amongst many staff and rendering effective change extremely difficult.

The wider politics around amalgamation were similar (if less powerful) in CHFT, however, the CEO and her management team approached local politics differently. They actively promoted the benefits of a united Trust in the local communities, appointed staff to develop positive community engagement, and looked for innovative ways to invest in, and contribute to, the communities. When it became apparent that they could not overcome politics and loyalties, they adapted their approach. Reasoning that the public were/are more concerned about the quality of the local hospitals and their care provision than who managed them, the senior managers ceased to promote the Trust, emphasising instead the professionalism and competence of the hospitals' staff and of the quality of the care. This outward proclamation of inner competence and coherency may have provided additional motivation for staff overcome their professional differences and to make a reality of joint working for patient benefit.

Given the tensions and cultural differences between the various professions in healthcare, such an effect should only have been beneficial in the drive towards greater patient involvement and focus in service provision. The chapters on the stances of sub-professional groups on various aspects of reform and performance improvement revealed that, though all groups supported some requirements for reorganising care, subgroups differed in the values they support, the power relations they normalised, the reforms they accepted, and the innovations they prioritised. These stances were, at times, paradoxical, *within* the professions as well as between them. The health literature demonstrates that considerable thought has been given to understanding and resolving tensions between medicine and general managers, and to a lesser extent, between nursing and medicine. However there has been relatively little attention paid to tensions between the full range of front line clinical professions, and between these

clinicians and their more office-immersed professional colleagues, that is, the clinical managers.

Furthermore, although staff often used 'the patient benefit' as justification and incentive for practice change, the research suggested that many staff still believed that professionals can define and pursue this *without* patient involvement. The literature review noted that this reluctance to involve patients in decision-making arises, at least in part, from a concern that including patients and their families in decision processes can have a destabilising impact within clinical teams. It may also partially be due to the increasing pressure on professional identities and boundaries. These pressures have multiple sources; key amongst them are medical advances and the proliferation of subspecialties, the increasing professionalisation agenda amongst staff with nursing and allied health backgrounds, and repeated governmental calls for role redefinition and more flexible ways of working. Such factors suggest that underlying systemic complexities and personal vulnerabilities need to be carefully managed when pursuing more coordinated and flexible approaches to care.

In Essence

This thesis has argued that entrenched differences in local and professional identities, values, and practices hinder wholesale change in the way that care is coordinated, conducted and managed. It also argued that significant and sustained change is unlikely to be brought about by people who are deeply immersed in local community and professional cultures. However, change programmes that ignore local history and values are also unlikely to succeed. Hence programmes that seek to challenge NHS and organisational norms in the management and performance of clinical work, and institutionalise new ones, cannot just be carefully constructed, comprehensive in coverage, and culturally sensitive. CEOs and senior managers must bring clarity of vision within the organisation about its goals, strategies and strengths, maintain stability in the midst of innovation, and balance 'localness' with freshness and energy.

Success depends as much as on the personnel and the 'personal' as it does on the programme.

Representativeness and Generalisability of the Conclusions

The applicability of these findings and conclusions to other organisational settings in the NHS depends, to a large degree, on the extent to which the depictions of the study Trusts, and their progress in institutionalising ICPs as 'the way of clinical work is done', adequately represent the 'real life' of the Trusts. It further depends on the extent to which the study Trusts are representative of Trusts elsewhere.

The degree of compliance between reality and depiction will always be debateable for the very terms 'organisation', 'Trust', 'profession', 'management', 'community' etc are abstract nouns, conceptualisations of things that are perceived to exist but cannot ever be proved. They are also reifications, condensations of fluid and informal group activities into a kind of congealed and objective whole (Wenger 1998)p. 61). As such, they can only ever be partial expressions of 'truth'. The question of representativeness then becomes one about the degree to which the thesis' depictions of the two Trusts 'resonate' with people familiar with these organisations and accord with depictions of other NHS organisations described by other researchers.

Whilst I cannot vouch for the first, I argue that the patterns of behaviours and values by staff, the leadership approaches described here, and the effect organisational architectures can have upon organisational functionality and outcomes, accord with the literature, historical and policy reviews discussed in the thesis. As such, my representations of the Trusts can be considered to be valid depictions of activity and organisational life in other NHS Trusts. I would therefore argue that the conclusions presented here are generally applicable to the wider NHS and to future national programmes that may seek to influence the organisation, coordination and management of clinical work, particularly any which might seek to reorient these more closely around the needs of specific patient groups.

Limitations of the Research Design

Had my research activity within the Trusts been more extensive, the findings may have diverged somewhat from those presented here. This includes findings about managerial and leadership competencies, the competing interests of professions, and the degrees of institutionalisation of the use of ICPs and support for more collaborative forms of working. Examples of possible extensions to the interview data collection include interviewing senior members of the Trust who had retired or otherwise left the Trusts, staff at different levels of the Trusts, and staff with differing degrees of managerial involvement. Utilising additional and/or alternative research techniques may also have produced somewhat differing data and conclusions. Examples of possible complementary research techniques include:

- Ethnographic research into the actual working practices of clinicians,
- Observational studies of clinical management meetings,
- A stakeholder analysis of change, and
- Semiotics and linguistic analysis.

The first three of these techniques may have led to a greater emphasis upon themes of conflict and power; the latter may have given greater insight into the linguistic and symbolic moves in the Trusts which helped or hindered progress towards the Trust goals in relation to the management of clinical work. A review of different literatures may well have identified different questions and themes which would have required alternative approach and method.

Defence of the Methods

In response to any charges that I interviewed too few people, I would argue that, as far as senior managements' perspectives were concerned, the majority of the executive team in both Trusts were interviewed. It was not appropriate under privacy and confidentiality legislation for Trusts to reveal the contact details of previous members of staff, especially those now retired and therefore without public roles. An initial attempt to recruit the clinical directors into the study received a very poor response. Whilst it may have been useful to pursue this more vigorously, interviewing the clinical directors in both Trusts would have weighted the balance of interviews towards NTH. Moreover,

the degree of tension between the senior executive and the clinical directors in NTH, and the difficulties experienced in both Trusts in obtaining senior clinicians' participation in CMD project workshops, suggested that requests for their time would have received short shrift, being regarded as detracting from, rather than continuing to, their work outcomes.

My choice of research methods was guided by my research question and the themes and issues identified from the literature review. As the list of relevant contextual factors in the coordination and management of care is potentially infinite, themes' apparent a` priori importance, and the practicality of researching these, played a significant part in my choice of research method. These included ideas about how to best understand healthcare as a system and the Trusts as organisations, a sense of what could practicably achieved in the relevant time span, and minimising research time spent away from my disabled son and my daughter (particularly important for me as a single parent). The realisation that this thesis is the start of a journey, not the end, encouraged me to accept both its limitations and its strengths as indicators of work that is yet to be done.

Future Research

Several areas for future research are suggested by the results and conclusions of this thesis. The first, and most immediately relevant, would seek to remedy one of the weaknesses of this study, namely a lack of understanding about how well the views of staff at various levels of each Trust, particularly in CHFT, accord with senior management's views about the meaning and importance of clinical work management. Though probably difficult to undertake (in terms of recruiting interview subjects), this would identify how staff experience discontinuities in understandings and priorities about how clinical work should be managed and, in so doing, provide background information to inform the second area of research.

The second possibility is an action research project to identify how the professional socialisations of clinicians and (professional and organisational) managers manifest during interactions between staff members, particularly in change programmes in NHS

organisations oriented towards greater collaboration in the provision and management of care for specific patient groups. As results emerge about discursive stances which may lead to misunderstandings, these can be fed back iteratively to participants. This should advance self-awareness and reflection, shared discursive and communicative skills, and mutual understanding in mediating the contradictions and discontinuities in stances that exist within and across professions.

The third area of research is similar to the second but incorporates patients and their families into the planning and decision making processes within NHS organisations. The thesis revealed that only a small percentage of staff in the study Trusts were keen to see more patient oriented services, and an even smaller percentage of staff wanted to include patients in key decision processes. As government policy is increasingly oriented to a patient-led NHS, an action research programme could, firstly, foster greater mutual understanding, better interpersonal communication, and improved relational skills. It could then use these attributes to develop shared approaches to patient inclusive decision-making, joint responsibility between patients and professionals for clinical outcomes, more effective team working and management, and newer managerial competencies centred on these.

A fourth research area concerns the extent to which the various research projects discussed above, and their outcomes in different Trusts, are influenced by locality specific factors and how these might be best managed. Such research could take various forms and/or use various research techniques e.g. action research, ethnographic approaches, observational studies, and discourse analysis. As the impact of locality specific factors is subtle and difficult to measure, a mix of approaches should provide greater wealth of insight and understanding than projects that rely on a single method.

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Appendices

Appendix One

Survey of Staff Views on Reform Values

A Survey of the Attitudes & Beliefs of Health Care Staff

University of Durham
Stockton Campus

Centre for Clinical Management Development

The aim of this questionnaire is to obtain your views about current moves to extend clinicians' involvement in management.

Involving clinicians more directly in management is a prominent issue in health policy circles. There are very few studies however which have examined what this might mean for the people who will be most affected. We therefore seek your opinion on a broad range of factors such as: the issues which face the health care system and the strategies that are appropriate for addressing them; the attributes which characterise different professional groupings; what you value about your work; how you perceive your professional autonomy and accountability; the factors that you believe affect clinical practice; your perceptions of how your clinical service and/or units should be managed; your assessment of how you are being managed and of the goals being pursued by your NHS Trust.

We realise that the task we are asking you to perform is demanding. Equally the process of involving clinicians in management is complex, and ultimately depends on how people like you respond. By sharing your views about matters such as those mentioned above you will give us a better understanding of how current changes in organising and managing health care services are affecting people such as yourself, and how you perceive and evaluate these changes.

Some additional points

1. We give an assurance that individuals responding to this questionnaire will not be identifiable in any reports of the findings.

2. You may interpret some of the statements in the questionnaire as contentious. They are included in the survey so that you can express your views about them.

3. There are no right or wrong answers to the questions we ask. We are simply interested in your views.

Thank you for giving us some of your valuable and hard-pressed time.

Personal Details

We would like to know a few of your personal details. We will use this information when we analyse your responses to the rest of the questionnaire.

Please indicate the response which **most closely describes** you and your work situation by ticking the appropriate box.

Gender:	Male	❑
	Female	❑
Age:	20-29	❑
	30-39	❑
	40-49	❑
	50-59	❑
	60 and over	❑

Your Occupation/Position

Please tick a box to identify your occupation. In the space provided indicate your specialisation and your status/grade.

Medicine: ❑

Specialisation _____

Status/Grade _____

(eg, consultant, registrar etc.)

Nursing: ❑

Specialisation _____

Status/Grade _____

Professions Allied to Medicine ❑

Specialisation _____

Status/Grade _____

Other not noted above _____

Percentage of Time Spent on: *Direct Patient Care ___%*

Administration/Management	___%
Teaching (excluding patient education)	___%
Research	___%
	100%

Length of Time in Current Role:	Less than 1 year	❑
	1-4 years	❑
	5-9 years	❑
	10-19 years	❑
	More than 20 years	❑
Terms of Your Employment:	Full-time salaried staff	❑
	Part-time salaried staff	❑
	Joint appointment with university	❑
	Other (Please specify)	
	_____	
Highest Professional Qualification:	Fellowship of College	❑
	Membership of College	❑
	Other (please specify): _____	
Highest Academic Qualification:	Postgraduate Degree	❑
	Postgraduate Diploma	❑
	Undergraduate Degree	❑
	Diploma	❑
	Certificate	❑
Highest Qualification in Management:	Postgraduate Degree	❑
	Postgraduate Diploma	❑
	Undergraduate Degree	❑
	Diploma	❑
	Certificate	❑
	In-house Short Course	❑
	None	❑

Health Care Issues

There are two parts to this section. Please answer both parts.

PART 1.

We are interested in your views on some issues that are said to face the health care system.

Note: By health professionals we mean all staff involved in direct patient care eg doctors, nurses and professions allied to medicine.

Rank the issues listed below from 1 to 6 according to your view of their relative importance.

Place the numeral "1" next to the issue that you think is **most important**. Then place the numeral "2" next to the issue that you think is **next most important** and so on, through to "6", for the issue that you think is **least important.**

In ranking the issues, do not use the same rank more than once.

In order of their importance in health care reform, I rank the issues listed below as follows:	(Rank)
• the increasing pressure on health professionals to base their clinical decisions on financial rather than strictly clinical grounds	[ ]
• the unwillingness of health professionals to consider the cost implications of their clinical practices	[ ]
• significant shortcomings in the accountability of health professionals	[ ]
• the increasing erosion of clinical autonomy by management	[ ]
• the inability of current information systems to monitor the clinical outcomes of clinical decision making	[ ]
• the inability of current information systems to monitor the cost implications of clinical decision making.	[ ]

PART 2.

We are interested in the importance that you give to a number of strategies for addressing resource issues that confront the **health care sector**.

For each of the strategies listed below, indicate your sense of its priority by circling the response on the scale provided which most closely corresponds with your view.

1 = High priority
2 = Middle order priority
3 = Low priority
4 = Not appropriate

To address resource issues that confront the health care sector, health authorities should:	
• increase government funding to health care	**1 2 3 4**
• implement quality management methodologies	**1 2 3 4**
• guide and support patients with chronic conditions to self manage their care	**1 2 3 4**
• stimulate public debate about the resource limits that should be placed on the **acute care** component of the health care system	**1 2 3 4**
• improve the ability of information systems to monitor clinical work	**1 2 3 4**
• require professional colleges to develop and implement care pathways	**1 2 3 4**
• charge local authorities for patients in hospital beds who are on waiting lists for nursing home and/or residential care services.	**1 2 3 4**
• establish structures and processes in clinical settings which reinforce the team based nature of service provision	**1 2 3 4**
• fund and manage high volume services on the basis of Integrated Care Pathways	**1 2 3 4**
• redirect resource flows from acute care to primary and secondary prevention	**1 2 3 4**
• stimulate public debate about the ethical limits of medical interventions	**1 2 3 4**
• develop services in primary care settings which enable more patients to be treated without resort to hospital inpatient services	**1 2 3 4**
• require Primary Care Trusts to take over responsibilities from local authorities for all aspects of social service delivery i.e. clients, budgets and staff.	**1 2 3 4**

Work Values

We are interested in your beliefs about social relationships within organisations *generally*.

Indicate the extent to which you 'agree' or 'disagree' with each of the statements listed below, by circling the response on the scale provided which most closely corresponds with your views.

1 = Strongly agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly disagree

• To get ahead at work you should never disagree with your superiors.	**1 2 3 4 5**
• In one's work, actions involving risk or chance should be avoided.	**1 2 3 4 5**
• It is best not to break the organisation's rules even when you think it may be in the organisation's best interest.	**1 2 3 4 5**
• The most effective manager is one who makes it clear who is the boss.	**1 2 3 4 5**
• It is right for people in positions of power to have some privileges.	**1 2 3 4 5**
• Be it at work or in the family, everyone should show respect to their authority figures	**1 2 3 4 5**
• One's work and private life should never mix.	**1 2 3 4 5**
• Decisions made by individuals are better than decisions made by groups.	**1 2 3 4 5**

Your Perception of Clinical Governance

There are two parts to this question. Please answer both parts.

PART 1.

We are interested in your views about the likely **clinical outcomes of *effective*** Clinical Governance.

Indicate the extent to which you 'agree' or 'disagree' with each of the statements listed below, by circling the response on the scale provided which most closely corresponds with your views.

1 = Strongly agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly disagree

Effective Clinical Governance implementation will:	
• Reduce patient complaints	**1 2 3 4 5**
• Increase patient satisfaction	**1 2 3 4 5**
• Increase efficiency	**1 2 3 4 5**
• Reduce the use of ineffective treatments	**1 2 3 4 5**
• Improve clinical outcomes	**1 2 3 4 5**
• Produce less unexplained variation in clinical practice	**1 2 3 4 5**
• Reduce critical incidents and adverse events	**1 2 3 4 5**
• Reduce hospital acquired infection rates	**1 2 3 4 5**

PART 2.

We are interested in how you evaluate the **organisational** effects of Clinical Governance.

Note: By health professionals we mean all staff involved in direct patient care eg doctors, nurses and professions allied to medicine.

Indicate the extent to which you 'agree' or 'disagree' with each of the statements listed below, by circling the response on the scale provided which most closely corresponds with your views.

1 = Strongly agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly disagree

I regard clinical governance as:	
• a fad whose time will pass	**1 2 3 4 5**
• a good idea whose potential cannot be realised because the resources required for its implementation are not available	**1 2 3 4 5**
• a mechanism for promoting further unjustified intrusions by management into clinical domains	**1 2 3 4 5**
• generating structures through which multidisciplinary clinical teams (eg. an orthopaedic unit or a renal unit) can systematise, monitor and improve care for specified treatments (eg. hip replacements)	**1 2 3 4 5**
• generating structures which (by using external discipline and surveillance) will encourage a culture of blame within clinical settings	**1 2 3 4 5**
• generating structures which will enable health professionals to bring clinical quality and outcomes issues into their negotiations with health policy authorities.	**1 2 3 4 5**

Are there any comments that you would like to make about Clinical Governance?

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Autonomy

We are interested in your perception of how certain expectations can affect your **professional** autonomy.

For each of the statements listed below, indicate its effect on **your autonomy** by circling the response on the scale provided which most closely corresponds with your views.

1 = Will **significantly extend** my autonomy
2 = Will **extend** my autonomy
3 = Have **no effect** on my autonomy
4 = Will **threaten** my autonomy
5 = Will **significantly threaten** my autonomy

An expectation that I:	
• routinely participate with my peers from my profession in reviews of my individual clinical work	**1 2 3 4 5**
• participate with all members of my multidisciplinary clinical team in planning, evaluating and improving the team's collective performance	**1 2 3 4 5**
• undertake administrative/clerical work	**1 2 3 4 5**
• use care pathways **specified by my clinical college** or **professional body**	**1 2 3 4 5**
• use care pathways **developed collectively with local professional peers**	**1 2 3 4 5**
• consider the resource implications of the tests and treatments that I order for individual patients	**1 2 3 4 5**
• become involved in the day-to-day management of my clinical unit or service.	**1 2 3 4 5**

Clinical Practice

There are three parts to this question. Please answer all three parts.
PART 1.

We are interested in your views about factors which may produce variations in clinical practice

For each of the factors listed below, indicate its importance as an explanation of variation in clinical practice by circling the response on the scale provided which most closely corresponds with your views.

1 = An **extremely important** factor
2 = A **very important** factor
3 = A **moderately important** factor
4 = A **slightly important** factor
5 = **Not important** at all

Variations in clinical practice are caused by:	
• shortcomings in the clinical education of medical, nursing and other clinical staff	**1 2 3 4 5**
• the indeterminacy of clinical signs and symptoms exhibited by many patients	**1 2 3 4 5**
• the failure of clinical colleges and/or professional bodies to develop and disseminate integrated care pathways	**1 2 3 4 5**
• shortcomings in local peer review structures and processes	**1 2 3 4 5**
• the inability of my profession's knowledge-base to encompass the complexity of the situations with which we have to deal	**1 2 3 4 5**
• the failure of individual health professionals to keep up-to-date with recent advances in their field	**1 2 3 4 5**
• shortcomings in clinical information systems	**1 2 3 4 5**
• the relative isolation of health professionals from each other which impedes knowledge sharing.	**1 2 3 4 5**

In the spaces provided, indicate your assessment of the importance of clinical practice variation as an issue requiring attention. (tick one box only)

Extremely	Very	Moderately	Slightly	Not at all
❑	❑	❑	❑	❑

PART 2.

We are interested in your views on a range of factors which can affect **your** clinical practice.

For each of the matters listed below nominate a **percentage** which represents your *best guess* of its prevalence in your clinical work.

In approximately what percentage of patients:	
• do you expect to encounter clinical signs and symptoms which are "outside the norm"?	_____%
• do you expect to encounter clinical signs and symptoms which are "not explainable"?	_____%
• do you expect treatment outcomes which are outside what you would regard as being "normal"?	_____%
• do you expect treatment outcomes which are outside what you would regard as being "explainable"?	_____%
• can you demonstrate a cause-effect relationship between the intervention performed and its expected clinical outcomes?	_____%
• is there general agreement within your **clinical specialty** about the techniques and regimens that should be used in treatment?	_____%
• do you and your **professional/clinical colleagues** agree about the techniques and regimens that should be used in treatment?	_____%
• do you feel free to vary the techniques and regimens that you use from those that are used by your professional/clinical colleagues?	_____%
• can you predict the amount of resources (for example, nursing time, imaging, pathology, pharmacy) that you require to produce a desired clinical outcome?	_____%
• are you doubtful about your capacity to produce a good clinical outcome?	_____%

PART 3.

We are interested in your experience with different methods of monitoring and managing clinical work.

For each of the matters listed below, rate your **experience** in implementing them by circling the response on the scale provided which most closely corresponds with your views.

1 = **As extensive** (ie I am an expert)
2 = **As proficient** (ie I am competent)
3 = **As moderate** (ie I have some experience but there are gaps)
4 = **As slight** (ie I have some grasp of what this is about)
5 = **As non existent** (ie I have no idea what you are referring to)

I rate my experience of :	
• clinical effectiveness review	**1 2 3 4 5**
• clinical audit	**1 2 3 4 5**
• quality improvement	**1 2 3 4 5**
• casemix	**1 2 3 4 5**
• review of resource utilisation in clinical practice	**1 2 3 4 5**
• clinical risk management	**1 2 3 4 5**
• care pathway development and implementation	**1 2 3 4 5**
• analysis of clinical practice variation	**1 2 3 4 5**
• encouraging change in clinical practice.	**1 2 3 4 5**

Resource Allocation

We are interested in your views about resource allocation.

Indicate the extent to which you 'agree' or 'disagree' with each of the statements listed below, by circling the response on the scale provided which most closely corresponds with your views.

1 = Strongly agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly disagree

• Resource allocation decisions should be based solely on the needs of individual patients, as determined by the health professionals immediately involved.	**1 2 3 4 5**
• Resources should not be allocated to a new clinical procedure/ treatment/service until its efficacy has been demonstrated through clinical trials.	**1 2 3 4 5**
• All clinical decisions are resource decisions.	**1 2 3 4 5**
• In today's economic climate, cost and efficiency concerns have to take precedence over concerns about equity and access.	**1 2 3 4 5**
• Clinical and/or health interventions should be open to economic assessment.	**1 2 3 4 5**
• Resource issues have no place in clinical decision making.	**1 2 3 4 5**
• Continually increasing the financial accountability of health professionals will cause them to compromise their responsibilities to individual patients.	**1 2 3 4 5**

Are there any comments that you would like to make about resource allocation?

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Accountability

We are interested in your perceptions of the scope and limits of **your** accountability

For each of the accountability arrangements listed below indicate the extent to which it falls within your perception of **your accountability** by circling the response on the scale provided which most closely corresponds with your view.

1 = Is **very important** in how I perceive my accountability
2 = Is **important** in how I perceive my accountability
3 = Is **slightly important** in how I perceive my accountability
4 = Is **irrelevant** to how I perceive my accountability
5 = **Contradicts** with how I perceive my accountability

An expectation that I:	
• answer to **myself** for the way that I have acted in the interest of each of my patients	**1 2 3 4 5**
• participate with all staff in my **clinical team** in evaluating and improving the team's collective performance	**1 2 3 4 5**
• answer to **management** for the resource implications of my clinical practices	**1 2 3 4 5**
• answer to **myself** for the way that I have balanced the needs of individual patients with those of all other patients, particularly with respect to resource usage	**1 2 3 4 5**
• collectively review my clinical work with my **professional/ clinical peers** using evaluation criteria we have defined	**1 2 3 4 5**
• have my clinical work routinely reviewed by **senior members of my clinical specialty** using evaluation criteria defined by them	**1 2 3 4 5**
• be open to **public scrutiny** and provide justification for my clinical practices and resulting clinical outcomes	**1 2 3 4 5**
• answer to **my patients** for my clinical practices and resulting clinical outcomes.	**1 2 3 4 5**

Setting Standards for Clinical Care

We are interested in your views about how standards should be set for clinical care.

Indicate the extent to which you 'agree' or 'disagree' with each of the statements listed below, by circling the response on the scale provided which most closely corresponds with your views.

1 = Strongly agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly disagree

Clinical standards should be based on:	
• a health professional's view of what works for her or him	**1 2 3 4 5**
• locally accepted practice patterns within a clinical unit or service	**1 2 3 4 5**
• documented and evaluated practice patterns across a number of clinical units or health care agencies	**1 2 3 4 5**
• the latest developments in the relevant literature	**1 2 3 4 5**
• protocols set by clinical colleges and/or professional bodies	**1 2 3 4 5**
• what is acceptable to patients	**1 2 3 4 5**
• what is feasible within existing resources.	**1 2 3 4 5**

Views on Managing Clinical Units

We are interested in your perception of the strategies that are appropriate for improving a **clinical unit's or service's** overall performance.

Indicate the extent to which you 'agree' or 'disagree' with each of the statements listed below, by circling the response on the scale provided which most closely corresponds with your views.

1 = Strongly agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly disagree

To improve a unit/service's overall performance, the person in charge should:	
• reinforce the expert authority of medical clinicians	**1 2 3 4 5**
• emphasise the financial dimensions of their unit or service's performance	**1 2 3 4 5**
• establish systems which will closely **monitor the work performance of each health professional** working in their unit/service	**1 2 3 4 5**
• get more resources for their unit or service from the corporate level of the NHS Trust	**1 2 3 4 5**
• establish structures and routines which encourage staff, **collectively**, to evaluate and improve their work practices	**1 2 3 4 5**
• devote significant time and resources to team building and staff development.	**1 2 3 4 5**

Organisational Assessment

There are three parts to this section. Please complete all three parts.

PART 1.

We are interested in the organisational characteristics that you believe are **exhibited by your NHS Trust.**

We explore these characteristics via five dimensions set out below. Each dimension contains four descriptions of how an NHS Trust could be managed.

For each dimension, distribute **a total of 100 points** among the four nominated alternatives depending on how similar you think each description is to **your experience** in your NHS Trust.

You may use any combination adding up to 100, for example, (20, 30, 50, 0 or 10, 40, 20, 30). Note: 100 = 'totally descriptive' and 0 = 'not descriptive at all'.

(A). Management Style:	(Points)
• Managers treat staff as their **equals** and include them in decision making processes.	[ ]
• Managers encourage staff to meet organisational **goals** and **objectives** and help them be productive.	[ ]
• Managers treat staff as **subordinates** but also try to develop a sense of **loyalty** and group spirit.	[ ]
• Managers ensure that staff **comply** with the Trust's rules.	[ ]
	100

(B). Direction & Co-ordination:	(Points)
• Individual staff are given a lot of **freedom** to determine their **own** activities.	[ ]
• Staff are clearly **told** what the Trust's goals and objectives are and then allowed a **fair degree of freedom** in deciding how they can meet these.	[ ]
• Managers have **developed** their staff into strong **work teams** which they **control** in a decentralised way.	[ ]
• Most staff, including managers, have **little choice** over what they do or how they do their jobs.	[ ]
	100

(C). Affiliation to the NHS Trust:	(Points)
• Staff personally **believe in** and **support** the Trust's overall purpose or mission.	[ ]
• Staff value being part of a Trust that emphasises **personal achievement**.	[ ]
• Staff feel a sense of **belonging and loyalty** to their particular work group and immediate manager.	[ ]
• Staff share the view that **rules** have to be followed whether they personally like them or not.	[ ]
	100

(D). How people relate and deal with conflict:	(Points)
• People put a strong emphasis on **getting on with one** another and resolving disputes in ways that preserve their relationship.	[ ]
• People value getting on with one another but **competition** is also encouraged in order to increase performance.	[ ]
• People are expected to **support their immediate manager** and the members of their particular work group when disputes arise.	[ ]
• People tend to **rely on rules** and policies for resolving disputes if they occur.	[ ]
	100

(E). The reward system emphasises:	(Points)
• Providing people with a sense of **satisfaction and involvement** in their work.	[ ]
• Rewarding people for their **individual achievement** and initiative.	[ ]
• Rewarding **groups** and units that achieve the objectives they have been set.	[ ]
• Rewarding people who hold **important, high-ranking** jobs.	[ ]
	100

PART 2.

We are interested in your perceptions of your **NHS Trust's** organisational goals.

In the spaces provided, rank the statements below from 1 to 8 in terms of your perception of their importance as goals of this Trust.

Place the numeral "1" next to the statement that you think is **most important**. Then place the numeral "2" next to the statement that you think is **next most important** and so on through to "8" for the statement that you think is **least important**.

In ranking the factors, do not use the same rank more than once.

In rank order, I believe the goals that are currently being pursued in this Trust are:	(Rank)
• staff welfare	[ ]
• organisational stability	[ ]
• equal access for all patients from the local community	[ ]
• financial viability	[ ]
• reputation for service innovation and industry leader	[ ]
• service quality	[ ]
• improved productivity	[ ]
• teaching and research reputation.	[ ]

PART 3.

We are interested in the general feelings you hold about the **NHS Trust** in which you are located.

Indicate the extent to which you 'agree' or 'disagree' with each of the statements listed below, by circling the response on the scale provided which most closely corresponds with your views.

1 = Strongly agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly disagree

• What the Trust stands for is important to me.	1 2 3 4 5
• I "talk up" the Trust to my friends as a great organisation to work for.	1 2 3 4 5
• If the values of this Trust were any different from what they are, I would not be as committed to this organisation.	1 2 3 4 5
• How hard I work for the Trust is directly linked to how much I am rewarded.	1 2 3 4 5
• In order for me to get rewarded around here, it is necessary to express the right attitude.	1 2 3 4 5
• Since working at the Trust, my personal values and those of the Trust have become more similar.	1 2 3 4 5
• My private views about the Trust are different from those I express publicly.	1 2 3 4 5
• The reason I prefer this Trust to others is because of what it stands for, that is, its values.	1 2 3 4 5
• Unless I'm rewarded for it in some way, I see no reason to expend extra effort on behalf of the Trust.	1 2 3 4 5
• I am proud to tell others that I am part of this Trust.	1 2 3 4 5
• I feel a sense of "ownership" for this Trust rather than being just an employee.	1 2 3 4 5
• Right now, staying with this Trust is a matter of necessity.	1 2 3 4 5
• Too much in my life would be disrupted if I decided I wanted to leave my Trust now.	1 2 3 4 5

What Would You Change?

We are interested in any changes which you believe will enhance your clinical performance and experience of work.

In the space provided below list changes in funding, organising and/or managing which you believe will significantly improve:

Your Clinical Performance

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Your Experience of Work

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Role of Primary Care Trusts

We are interested in your perceptions of the role of **Primary Care Trusts** in improving the performance of your **local health economy/community**.

In the spaces provided, indicate the extent to which you believe that Primary Care Trusts have a role in bringing about changes to improve the performance of the local health economy/community.

(tick one box only)

Strongly agree	Agree	Slighty Agree	No Role	Don't Know
❑	❑	❑	❑	❑

If you have indicated that the Primary Care Trust *has a role* in bringing about change, nominate strategies you believe it should pursue.

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In the space below, list the factors that you believe will facilitate or hinder the Primary Care Trusts' capacity to fulfill these strategies.

Facilitating factors:

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Hindering factors:

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The Local Health Economy/Community

We are interested in any further thoughts you have on how services might be improved.

In the spaces provided below, specify any *changes* you believe need to be made in the focus, funding and/or management of Acute Trusts, General Practice and Social services to improve the efficiency and effectiveness of your local health economy/community.

Acute Care Trusts

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General Practices

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Social Services

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We would like to take this opportunity to thank you for taking the time and effort to complete this questionnaire

Feel free to use this space to comment on any issues raised in the survey

Appendix Two

Interview Questions

I am interested in understanding the factors that influence the management strategies and work practices that NHS organisations are adopting in response to the government's drive for NHS reform.

Trust

CHT	☐
NTH	☐

Your Occupation/Position

CEO	☐	
Executive Medical Director	☐	
Divisional Medical Director	☐	Division .....
Executive Allied Health Director	☐	
Divisional Allied Health Director	☐	Division .....
Executive Director of Nursing	☐	
Divisional Director of Nursing	☐	Division .....
Finance Director	☐	
Performance Director	☐	
Clingov Director	☐	
OD Director	☐	
Personnel Director	☐	
Operations Director	☐	
HR Director	☐	
IMT Director	☐	
Pathways Coordinator	☐	
Clinical Audit Manager	☐	

Gender

Male	☐
Female	☐

Age

20-29	☐
30-39	☐
40-49	☐
40-59	☐
60+	☐

Percentage of Time Spent on

Direct Patient Care	___%
Administration/Management	___%
Teaching (excluding patient education)	___%
Research	___%
	100%

Length of Time in Current Role:

Less than 1 year	☐
1-4 years	☐
5-9 years	☐
10-19 years	☐
More than 20 years	☐

Highest Professional Qualification:

Fellowship of College	☐
Membership of College	☐
Other (please specify):	.....

Highest Academic Qualification:

Postgraduate Degree	☐
Postgraduate Diploma	☐
Undergraduate Degree	☐
Diploma	☐
Certificate	☐
None	☐

Highest Qualification in Management:

Postgraduate Degree	☐
Postgraduate Diploma	☐
Undergraduate Degree	☐
Diploma	☐
Certificate	☐
In-house Short Course	☐
None	☐

Career Progression

1. .....
2. .....
3. .....
4. .....
5. .....

Do you intend to upgrade your qualifications?

Yes, clinical qualifications	☐
Yes, mangemnt qualifications	☐
No	☐

Do you have an agreed job description?

Yes	☐
No	☐

Do you have a performance agreement?

Yes	☐
No	☐

If yes to either, please provide a copy.

Reform Strategies

1. What do you think are the trust's current top three priorities?

1.....

2.....

3.....

2. What do you think ***should be*** the trust's order of priorities?

1.....

2.....

3.....

3 a) Can you detail any of the trust's specific initiatives for meeting these priorities?

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.....

3b). Can you detail any of the trust's specific initiatives for improving efficiency?

.....

.....

.....

3c) Can you detail any of the trust's initiatives for improving clinical effectiveness?

.....

.....

.....

3d) Can you detail any of the trust's specific initiatives for service redesign?

.....

.....

.....

4. What would you regard as the prime drivers for the adoption of these specific initiatives?

.....

.....

.....

.....

5. What factors have/are facilitated the implementation of these initiatives?

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6. What barriers to change where encountered when attempting to implement the initiatives you named above?

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.....

7. What, if anything, do you think *could* be done to meet the trust's priorities, that is **not** being done?

.....
.....
.....

9. Why do you think this/these are not being done?

.....
.....
.....

10. NHS reforms are designed to improve the effectiveness and efficiency of care and the wider NHS. Policies directed at these goals encompass a variety of elements. On a scale of 1-5, how do you rate **your unit's** ability to meet the requirements on each of these policies?

1 = Not well prepared at all
2 = Plans developed but strategy initiatives yet to be implemented
3 = Implementation of initiatives underway but struggling to progress
4 = Implementation of strategy proceeding according to expectation
5 = All plans implemented and working well
6 = NA
7 = DK

o Linking funding to activity (PbR)	1 2 3 4 5 6 7
o Linking clinical practice and resource use	1 2 3 4 5 6 7
o Introduction of patient choice	1 2 3 4 5 6 7
o Increased patient and public involvement in organisational decision-making	1 2 3 4 5 6 7
o Increased transparency of work	1 2 3 4 5 6 7
o Increased accountability for managers	1 2 3 4 5 6 7
o Use of performance targets	1 2 3 4 5 6 7
o Evidenced based practice	1 2 3 4 5 6 7
o Staff role redesign	1 2 3 4 5 6 7
o Multidisciplinarity in delivery of care	1 2 3 4 5 6 7
o Service redesign	1 2 3 4 5 6 7
o Shifting the balance of power towards primary care	1 2 3 4 5 6 7
o Increased collaboration across health economy	1 2 3 4 5 6 7
o Increased competition	1 2 3 4 5 6 7
o Practice based commissioning	1 2 3 4 5 6 7
o IT Improvement	1 2 3 4 5 6 7

11. On a scale of 1-5 (one being 'not well prepared at all' and five being 'all plans implemented and working well'), how do you rate **your trust's** ability to meet the requirements on each of these policies?

1 = Not well prepared at all
2 = Plans developed but strategy initiatives yet to be implemented
3 = Implementation of initiatives underway but struggling to progress
4 = Implementation of strategy proceeding according to expectation
5 = All plans implemented and working well
6 = NA
7 = DK

o Linking funding to activity (PbR)	1 2 3 4 5 6 7
o Linking clinical practice and resource use	1 2 3 4 5 6 7
o Introduction of patient choice	1 2 3 4 5 6 7
o Increased patient and public involvement in organisational decision-making	1 2 3 4 5 6 7
o Increased transparency of work	1 2 3 4 5 6 7

o	Increased accountability for managers	1 2 3 4 5 6 7
o	Use of performance targets	1 2 3 4 5 6 7
o	Evidenced based practice	1 2 3 4 5 6 7
o	Staff role redesign	1 2 3 4 5 6 7
o	Multidisciplinarity in delivery of care	1 2 3 4 5 6 7
o	Service redesign	1 2 3 4 5 6 7
o	Shifting the balance of power towards primary care	1 2 3 4 5 6 7
o	Increased collaboration across health economy	1 2 3 4 5 6 7
o	Increased competition	1 2 3 4 5 6 7
o	Practice based commissioning	1 2 3 4 5 6 7
o	IT Improvement	1 2 3 4 5 6 7

Your Role

12. What do you regard as your primary responsibilities in your current role?

    1. .....
    2. .....
    3. .....
    4. .....
    5. .....

13. On a scale of one to five, how much of your time is spent on the following activities?

    1 = None
    2 = Very little
    3 = Some of my time
    4 = A moderate amount of time
    5 = Most of my time
    6 = NA
    7 = DK

- o 'Putting out fires' 1 2 3 4 5 6 7
- o Preventing fires 1 2 3 4 5 6 7
- o Dealing with 'burns victims' 1 2 3 4 5 6 7
- o Consciously responding to central policy directives 1 2 3 4 5 6 7
- o Working in a multidisciplinary capacity 1 2 3 4 5 6 7
- o Maintaining organisational stability 1 2 3 4 5 6 7
- o Relating to collaborating care providers external to the trust 1 2 3 4 5 6 7
- o Dealing with minutiae and mundane matters 1 2 3 4 5 6 7
- o Reviewing clinical systems 1 2 3 4 5 6 7
- o Addressing clinical issues 1 2 3 4 5 6 7
- o Developing, maintaining or reviewing internal non-clinical management systems 1 2 3 4 5 6 7
- o Addressing competitive concerns 1 2 3 4 5 6 7
- o Reflecting on the bigger picture 1 2 3 4 5 6 7
- o Dealing with financial concerns 1 2 3 4 5 6 7
- o Achieving things you regard as core to your role 1 2 3 4 5 6 7
- o Achieving you regard as core to the trust's goals 1 2 3 4 5 6 7
- o Receiving encouragement and support from others 1 2 3 4 5 6 7

14. What are the three things you would most like to achieve in this position?

Personally.....
.....
Professionally.....
.....
Organisationally.....
.....

15. What is the one barrier, that if removed or changed, would make your job easier?

Personal.....

.....

Professional.....

.....

Organisational .....

.....

In the wider NHS context .....

.....

16. How you determine what you think is expected of you in undertaking your role and in making decisions?

.....

.....

.....

17. What personal attributes do you think are most respected and/or admired in this trust?

.....

.....

.....

18. Do you think you tend to see things differently from others with whom you work? In what ways?

.....

.....

.....

The Role of Clinical Work

19. What does the term 'managing clinical work' mean to you?

.....

.....

20. Can you give an example of your unit's success in managing clinical work?

.....

.....
.....

21. Would you say this kind of success is reasonably rare or a common occurrence?
Rare □ Occasional □ Becoming frequent □ Common occurrence □

22. Can you describe a colleague who was very helpful in achieving the success?:

a) What did they do?
.....
.....

b) What is their official role?
.....
.....

c) What appears/ed to motivate this person?
.....
.....

d) What **personal characteristic** most enabled them to assist achieve this success?
.....
.....

e) What factors at the **team level** aided this person/the success?
.....
.....

e) What factors at the **unit level** aided this person/the success?
.....
.....

f) What factors at **divisional level** aided this person/the success?
.....
.....

g) What factors at **senior management level** aided this person/the success?
.....
.....

23. Can you outline some strategies that **your unit** could adopt to better manage clinical work?
.....
.....
.....

24. Can you outline some strategies that **the trust** could adopt to better manage clinical work?
.....
.....
.....

25. What impedes **your unit** in pursuing these strategies?

.....
.....
.....

26. What impedes **the trust** in pursuing these strategies?

.....
.....
.....

(Obtain first responses then ask about:)
a) Internal dynamics

.....
.....
.....

b) External contextual impediments

.....
.....
.....

c) Historically based impediments

.....
.....
.....

Summary Items

27. What are the trust's strongest facilitating factors for successfully meeting its goals?

1. .....
2. .....
3. .....
4. .....
5. .....

28. What are the trust's strongest impediments to meeting its goals?

1. .....
2. .....
3. .....
4. .....
5. .....

29. On a scale of 1-5, to what extent would you say that **staff** in this trust are driven by:

1 = Almost never
2 = A little
3 = Moderately
4 = Quite strongly
5 = Very strongly
6 = Don't Know

a) A need to meet rules, regulations and targets	1 2 3 4 5 6
b) A commitment to meet an ideal	1 2 3 4 5 6
c) 'Obvious' and/or unacknowledged assumptions	1 2 3 4 5 6
d) Financial and status rewards	1 2 3 4 5 6
e) Their personal and professional values	1 2 3 4 5 6
f) What they think is expected of them	1 2 3 4 5 6

29. On a scale of 1-5, to what extent would you say that, when making decisions at work, **you** are influenced by:

1 = Almost never
2 = A little
3 = Moderately
4 = Quite strongly
5 = Very strongly
6 = Don't Know

a) A need to meet rules, regulations and targets	1 2 3 4 5 6
b) A commitment to meet an ideal	1 2 3 4 5 6
c) 'Obvious' and/or unacknowledged assumptions	1 2 3 4 5 6
d) Financial and status rewards	1 2 3 4 5 6
e) My personal and professional values	1 2 3 4 5 6
f) What I think is expected of me	1 2 3 4 5 6

31. If your nephew or niece was to start with for this Trust tomorrow, what advice would you give them to help them get ahead?.....
.....
.....

32. Complete this sentence: "I work for this trust because .....
.....
....."

Thank you for your time.

10. On a scale of 1-5, how do you rate **your unit's** ability to meet the requirements on each of these policies?

1 = not well prepared at all
2 = planning begun but strategy initiatives yet to be implemented
3 = implementation of initiatives underway
4 = implementation of strategy nearing completion
5 = all plans implemented and working well
6 = NA
7 = DK

o Linking funding to activity (PbR)	1	2	3	4	5	6	7
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o Evidenced based practice	1	2	3	4	5	6	7
o Staff role redesign	1	2	3	4	5	6	7
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o Practice based commissioning	1	2	3	4	5	6	7
o IT Improvement	1	2	3	4	5	6	7